



RESIDENTIAL OPTIONS WAIVER (ROW)

Chapter Thirty-Eight of the Medicaid Services Manual

Issued December 1, 2011

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

The purpose of the Residential Options Waiver (ROW), a 1915(c) home and community-based services (HCBS) waiver, is to assist beneficiaries in leading healthy, independent, and productive lives to the fullest extent possible and to promote the full exercise of their rights as citizens of Louisiana. Services are provided with the goal of promoting independence through strengthening the beneficiary’s capacity for self-care and self-sufficiency. ROW is a person-centered waiver incorporating the beneficiary’s support needs and preferences with a goal of integrating the beneficiary within the community.

ROW provides an opportunity for eligible individuals with intellectual disabilities to transition from an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or from a nursing facility placement, by creating community-based alternatives in home settings along with an array of comprehensive supports for those individuals with intensive and/or complex needs.

There is no age restriction as part of the ROW eligibility determination.

The objectives of the ROW are to:

1. Promote independence for beneficiaries 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 beneficiary safeguards;
2. Offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks; and
3. Offer access to services, which would protect the health and safety of the beneficiary.

The Louisiana Department of Health (LDH) Bureau of Health Services Financing (BHSF) is the single state Medicaid agency that maintains administrative and supervisory oversight of the ROW. The department within BHSF that has oversight authority of the ROW is the Medicaid Program Support and Waivers (MPSW) section. BHSF MPSW designates the authority for implementation and programmatic oversight of the waiver to the Office for Citizens with Developmental Disabilities (OCDD) through an interagency agreement, with responsibility for day-to-day operations delegated to local governing entities (LGEs).

ROW services are accessed through a single point of entry in the LGE.

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As part of OCDD’s Tiered Waiver approach, all children under age 21 enter the waiver system into the Children’s Choice (CC) Waiver and all adults enter into the Supports Waiver (SW). If a beneficiary’s needs cannot be met within the initial/current waiver, they may request to move up to the next waiver in the tier. ROW is the second tier within the OCDD Tiered Waiver process.

Beneficiaries may exceed assigned ROW acuity/budget cap level(s) to access defined additional support needs to prevent institutionalization on a case-by-case basis according to policy and as approved by the OCDD assistant secretary or their designee.

This program is not intended to provide continuous 24 hours a day one-to-one supports. However, 24 hours a day one-to-one supports may be provided for short terms during period of crisis or changing needs. Services should be return to assigned I-Cap acuity budget level with resolution of crisis.

If it is determined that the ROW can no longer meet the beneficiary’s health and safety and/or support the beneficiary, the support coordination agency will conduct person centered discovery activities to discover what services are needed.

All Medicaid service options will be explored, including intermediate care facilities for individuals with intellectual disabilities (ICF/IID) placement, based upon the assessed need.

All waiver beneficiaries choose their support coordination and direct service provider agencies through the freedom of choice (FOC) process.

The plan of care (POC) shall be developed using a person-centered process coordinated by the beneficiary’s support coordinator. The initial POC developed during this person-centered planning process must be approved by the LGE. The support coordination agency supervisor as allowed by OCDD policy may approve annual reassessments.

All services must be prior authorized and delivered in accordance with an approved POC. Prior authorization (PA) is completed through an independent entity contracted by LDH that also maintains the service data on all waivers for the intellectually disabled population.

ROW services are accessed through the beneficiary’s support coordinator and are based on the individual needs and preferences of the beneficiary. A beneficiary’s support team consists of the following persons:

1. Support coordinator;
2. Authorized representative;

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3. Appropriate professionals;
4. Service providers; and
5. Others whom the beneficiary chooses to develop the beneficiary’s POC through a person centered planning process.

The POC contains all services and activities involving the beneficiary, including non-waiver services as well as waiver support services. The average beneficiary’s expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF/IID services. The completed POC is submitted to the support coordination agency supervisor or LGE for review and approval as designated in OCDD policy. POCs approved by the support coordination agency supervisor shall be submitted to the LGE.

The ROW services include:

1. Community Living Supports;
2. Companion Care;
3. Supported Employment;
4. Day Habilitation;
5. Prevocational services;
6. Transportation Community Access;
7. Respite services;
 - a. Out of Home.
8. Shared Living Services.
9. Host Home;
10. Housing Stabilization Transition;
 - a. Housing Stabilization; and
 - b. One-time Transition Services.

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11. Environmental Accessibility Adaptations;
12. Assistive Technology/Specialized Medical Equipment and Supplies;
13. Personal Emergency Response System (PERS);
14. Professional Services;
15. Nursing;
16. Expanded Dental Services for Adult Waiver Beneficiaries;
17. Adult Day Health Care (ADHC);
18. Monitored In-Home Caregiving (MIHC);
19. Support Coordination;
20. Community Life Engagement Development (CLED); and
21. Financial Management Services (FMS).

The ROW gives the beneficiary or authorized representative an opportunity to act as the employer in the delivery of designated self-directed services. This option provides beneficiaries with maximum flexibility and control over their supports and services.

Providers are responsible for complying with the requirements in Chapter 1, General Information and Administration of the *Medicaid Services Manual*. This manual is available on the Louisiana Medicaid website under the “Provider Manuals” tab at: www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

The Medicaid data contractor is responsible for performing prior and post authorization of waiver services based on the information included in the beneficiary’s approved POC and services entered into the service provider data collection system. The LDH fiscal intermediary (FI) maintains a computerized claims processing system, with an extensive system of edits and audits, for payment of claims to providers.

Services provided in the ROW program must comply with the following Centers for Medicare and Medicaid Services (CMS) HCBS Settings criteria according to 42 CFR 441.530:

1. Beneficiaries receiving any ROW services are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as

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individuals without disabilities, as well as have opportunities to seek employment and work in competitive integrated settings. Additionally, beneficiaries have the right to control their personal resources, engage in community life, and receive services in the community to the same degree of access as individuals not receiving home and community based services;

2. The setting is selected by the beneficiary from among setting options, including non-disability specific settings and an option for a private unit in a residential setting;
3. The setting options are identified and documented in the POC and are based on the beneficiary's needs, preferences, and, for residential settings, resources available for room and board;
4. The setting ensures a beneficiary's rights of privacy, dignity and respect, and freedom from coercion and restraint, including the right to respectful interactions and privacy in both residential and non-residential settings;
5. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact;
6. Beneficiaries have choice regarding services and supports, and who provides them; and
7. Residential settings owned or controlled by the provider must also meet the following requirements:
 - a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of Louisiana, the parish, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement, or other form of written agreement will be in place for each HCBS beneficiary, and that the document provides protections that address eviction processes and appeals comparable to those provided under Louisiana's landlord/tenant law;
 - b. The setting where services are provided must be physically accessible to the beneficiary such that all areas of normal access are not restricted;

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- c. Beneficiaries can control their own schedules and activities, including access to food at any time to the same extent as beneficiaries who are not receiving Medicaid HCBS;
- d. Beneficiaries are able to have visitors of their choosing at any time;
- e. Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors, as needed. Beneficiaries in provider owned or controlled residential settings shall have privacy in their living or sleeping unit;
- f. Beneficiaries sharing units have a choice of roommates in that setting;
- g. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
- h. Staff may be shared across the CC or New Opportunities Waiver (NOW) at the same time;
- i. No reimbursement for ROW services shall be made for a beneficiary who is admitted to an inpatient setting except Support Coordination monthly flat rate; and
- j. Providers shall meet the requirements of the U.S. Department of Health and Human Services (DHHS), CMS home and community-based setting requirements for HCBS waivers as delineated in LAC 50:XXI.901 or any superseding rule.

The intent of this chapter is to provide a ROW provider the information needed to fulfill its vendor agreement with the state of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and LDH rules.

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COVERED SERVICES

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

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

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

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

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

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

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

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

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Support Coordination

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

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

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

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

Support Coordinator

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

Support coordination services include the following:

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

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

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

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

Service Units and Limitations

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

Community Living Supports

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

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Supports provided include the following:

Self-Help Skills:

1. Activities of daily living (ADL) and self-care (i.e., bathing, grooming, dressing, nutrition, money management, laundry, travel training, and safety skills);
2. Skills intended to increase level of independence; and
3. Travel-training to community activities/locations (not intended to be used when the beneficiary is learning to go to and from a vocational setting).

Socialization Skills:

1. Appropriate communication with others, both verbal and nonverbal (i.e., manners, making eye contact, shaking hands, and behavior); and
2. Skills intended to increase involvement in the community (i.e., church membership, voting, participation in sports, and volunteering).

Cognitive and Communication Tasks:

1. Learning activities - (i.e., attention to task, self-control, verbal/nonverbal communication, and interpersonal communication-verbal/nonverbal cues); and
2. Tasks intended to increase level of understanding and to communicate more effectively.

Acquisition of Appropriate, Positive Behavior:

1. Appropriate behavior – (i.e., non-aggression and appropriate social interaction); and
2. Intended to increase socially appropriate behavior.

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

1. Natural supports;
2. Support coordinator;

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- 3. Vocational provider; and/or
- 4. Professional provider.

Training components can include:

- 1. Self-help skills;
- 2. Socialization skills;
- 3. Cognitive and communication skills; and
- 4. Acquisition of appropriate/positive behavior.

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

Community Living Supports (Shared Supports)

CLS may be shared by up to 3 beneficiaries who may or may not live together and who have a common DSP. In order to share CLS, beneficiaries and their family/legal guardians must agree. In addition, CLS Direct Support Staff may be shared across the Children’s Choice (CC) or New Opportunities Waiver (NOW) at the same time. The health and welfare of each beneficiary must also be ensured. Shared staff must be reflected in each beneficiary’s POC and be based on an individual basis. A shared rate is billed when beneficiaries share CLS.

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

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

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

Transportation

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

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Service Units and Limitations

1. The CLS Service Unit is 15 minutes;
2. Family members who provide CLS services must meet the same standards as providers who are unrelated to the beneficiary. Service hours shall be capped at 40 hours per week/per staff, Sunday to Saturday, for services delivered by family members or legally responsible individuals living in the home;
3. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide CLS services for a beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary;
4. Authorized representatives, legally responsible individuals, and legal guardians may be the employers in the self-directed option but may not also be the employees;
5. Family members who are employed in the self-directed option must meet the same standards as direct support staff that are not related to the beneficiary;
6. Payment does not include room and board, maintenance, upkeep, and/or improvement of the beneficiary's or family's residence;
7. CLS staff providing services are not allowed to sleep during billable hours of CLS;
8. Provider may not bill for CLS for the same time on the same day as respite services;
9. CLS are not available to individuals receiving Shared Living Services, Host Home Services, or Companion Care Services (the same type of supports that CLS provides are integral to and built into the rate for these three services, and this prohibition prevents duplication of services);
10. Payment will not be made for travel training to vocational services;
11. Payment for services rendered are approved by prior and post authorization as outlined in the POC;

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12. Payments to legally responsible individuals, legal guardians, and family members living in the home shall be audited on a semi-annual basis to ensure payment for services rendered;
13. Both the beneficiary and the worker must be present in order for the provider to bill for this service. In no instance should a beneficiary be left alone when services are being provided;
14. Services cannot be provided outside the state of Louisiana, but within the United States or its territories, unless there is a documented emergency or a time-limited exception (not to exceed 30 days) which has been prior approved by the local governing entity (LGE) office and included in the beneficiary's POC;
15. Services are not allowed to be provided in the non-related DSW place of residence; and
16. CLS is not intended to provide continuous 24 hours a day one-to-one support.

CLS services may not be provided in the following locations:

1. A hospital, once the beneficiary has been admitted for inpatient services; or
2. Outside the United States or territories of the United States.

NOTE: Time spent on a cruise ship that leaves and returns to the same United States port of call is eligible for CLS services. Time spent off the cruise ship and in a foreign country or territory is not eligible for CLS services. Tickets for these types of trips should not be purchased until a revision to POC has been approved by the LGE office. Beneficiary funds are not allowed to be used to purchase travel tickets for DSWs accompanying the beneficiary on the trip without written approval from the LGE office.

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

1. Supported Employment;
2. Day Habilitation;
3. Prevocational Services;
4. Respite Care Services-Out of Home;
5. Transportation-Community Access;

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6. MIHC;
7. Adult Day Health Care (ADHC);
8. Companion Care; or
9. Community Life Engagement Development (CLED).

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

Reimbursement

The use of the electronic visit verification (EVV) system is mandatory for CLS Services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and the Office for Citizens with Developmental Disabilities (OCDD).

Host Home Services

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

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

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

Host Home services include assistance with:

1. Personal care – assistance with the ADL and adaptive living needs;
2. Leisure activities – assistance to develop leisure interests and daily activities in the home setting;

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3. Social development/ family inclusion – assistance to develop relationships with other members of the household; and
4. Community inclusion - supports in accessing community services, activities and pursuing and developing recreational and social interests outside the home.

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

Place of Service

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

Service Units and Limitations

1. Service Unit for Host Home services is a per-diem rate based on the beneficiary’s Inventory for Client and Agency Planning (ICAP);
2. Children eligible for Title IV-E services are not eligible for Host Home services;
3. Regardless of the funding source, a Host Home family shall not have more than 2 people for whom the Host Home family is receiving compensation; and
4. Host Home families must not allow more than three persons unrelated to the principal caregiver to live in the home.

Services Exclusions

1. Payment is not made for room and board or maintenance, upkeep, or improvement of the Host Home family’s residence;
2. Separate payment will not be made for the following services:
 - a. CLS;
 - b. Respite Care Services-Out of Home;
 - c. Shared Living/Shared Living Conversion;

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- d. Companion Care;
 - e. MIHC;
 - f. Transportation-Community Access;
 - g. Environmental Accessibility Adaptations; or
 - h. One-Time Transitional Services.
3. The Host Home Family may not be the owner or administrator of the Host Home provider agency in order to prevent a conflict of interest; and
4. Payment will not be made for services provided by a relative who is a:
- a. Parent(s) of a minor child;
 - b. Legal guardian of an adult or child with developmental disabilities;
 - c. Parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or
 - d. Spouse of the beneficiary.

Companion Care Services

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

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

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

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Companion Care services:

1. Focus on assisting the beneficiary to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community;
2. Provide assistance with the ADL as indicated in the beneficiary's POC;
3. Provide assistance with community access and coordination of transportation, including medical appointments;
4. Participate in, and follow, the beneficiary's POC and any other support plans;
5. Provide assistance/support consistent with the beneficiary's goals as identified in the beneficiary's POC; and
6. Maintain documentation/records in accordance with State and provider requirements.

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

1. Must be at least 18 years of age;
2. Must live with the beneficiary;
3. Must purchase personal food and personal care items;
4. Is a contracted employee of the provider agency and is paid a flat daily rate to provide limited, daily direct services as negotiated with the beneficiary;
5. Is available in accordance with a pre-arranged time schedule as outlined in the beneficiaries POC;
6. Is available 24 hours a day (by phone contact) to the beneficiary to provide supports on short notice as a need arises and for crisis support to ensure the health and safety of the beneficiary;
7. Legally responsible individuals and legal guardians may provide Companion Care services for a beneficiary provided; and
8. When the beneficiary requests the person as a roommate, living responsibilities and finances in the home are divided and shared with the provider agency, the care is provided in the beneficiary's residence and this service is in the best interest of the beneficiary,

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Beneficiary/Companion Agreement

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

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

Place of Service

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

Service Units and Limitations

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

Service Exclusions

1. Companion Care is not available to individuals receiving the following services:
 - a. Respite Care services - out of home;
 - b. CLS;
 - c. Host Home;
 - d. Shared Living services;
 - e. MIHC; or
 - f. Transportation-Community Access.
2. Companion Care services are not available to beneficiaries under the age of 18;

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3. Payment does not include room and board or maintenance, upkeep, or improvement of the beneficiary's or the provider's property;
4. Transportation for vocational services are to be billed by vocational providers; and
5. The Companion Care provider's rate includes funding for relief staff for scheduled and unscheduled absences.

Shared Living Services

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

A Shared Living provider delivers supports which include:

1. 24-hour staff availability;
2. Assistance with all ADL as needed and indicated in the POC;
3. A daily schedule;
4. Health and welfare needs;
5. Transportation;
6. Any non-residential ROW services delivered by the shared living services provider; and
7. Other responsibilities as required in each beneficiary's POC.

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

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

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

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

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

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

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

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

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

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

1. Opportunities for each beneficiary to seek employment and work in competitive integrated settings and engage in community life;
2. Control of personal resources; and
3. Receipt of services in the community like individuals without disabilities.

Shared Livings may include the Conversion Option or the Non-Conversion (new) Option.

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Shared Living Conversion Option

The shared living conversion option is only allowed for providers of homes that were previously licensed and Medicaid certified as an ICF/IID for up to a maximum of 8 licensed and Medicaid-funded beds on October 1, 2009, and should meet the following criteria:

1. The number of beneficiaries for the shared living conversion option shall not exceed the licensed and Medicaid-funded bed capacity of the ICF/IID on October 1, 2009, or up to 6 individuals, whichever is less;
2. The ICF/IID used for the shared living conversion option must meet the department's operational, programming, and quality assurances of health and safety for all beneficiaries;
3. The provider of shared living services is responsible for the overall assurances of health and safety for all beneficiaries; and
4. The provider of shared living conversion option may provide nursing services and professional services to beneficiaries utilizing this residential services option.

Shared Living Non-Conversion (New) Option

The shared living non-conversion option is allowed only for new or existing ICF/IID providers to establish a shared living waiver home for up to a maximum of 3 individuals. The shared living waiver home must:

1. Be located separate and apart from any ICF/IID;
2. Be a home owned or leased by the waiver beneficiaries or a home owned or leased and operated by a licensed shared living provider; and
3. Meet the department's operational, programming, and quality assurances for HCBS.

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

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

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

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2. Shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/IID prior to beginning the process of conversion; and
3. Shall submit a licensing application for an HCBS provider license, Shared Living Module.

ICF/IID Conversion

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

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

1. If choosing ROW services, persons may select any ROW services and provider(s) based upon FOC;
2. All Shared Living service beneficiaries are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their POC;
3. Family members who provide Shared Living services must meet the same standards as unrelated provider agency staff; and
4. Shared Living service providers are responsible for providing 24-hour staff member availability along with other identified responsibilities as indicated in each beneficiary's individualized POC. This includes responsibility for each beneficiary's routine daily schedule, for ensuring the health and welfare of each beneficiary while in their place of residence and in the community, and for any other waiver services provided by the Shared Living services provider.

Place of Service

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

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

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

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

1. The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant laws of the state, parish, city, or other designated entity;
2. Each beneficiary has privacy in their sleeping or living unit, which requires the following:
 - a. Units have lockable entrance doors, with appropriate staff having keys to doors;
 - b. Beneficiaries share units only at the beneficiaries' choice; and
 - c. Beneficiaries have the freedom to furnish and decorate their sleeping or living units.
3. Beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time;
4. Beneficiaries are able to have visitors of their choosing at any time; and
5. The setting is physically accessible to the beneficiary.

Transportation

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

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Service Units and Limitations

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

1. Include room and board or maintenance, upkeep, or improvements of the beneficiary's or the provider's property; or
2. Be made for environmental accessibility adaptations when the provider owns or leases the residence.

Beneficiaries may receive one-time transitional services only if the beneficiary owns or leases the home and the service provider is not the owner or landlord of the home. Money Follows the Person (MFP) beneficiaries cannot participate in ROW shared living services that serve more than 4 persons in a single residence.

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

Service Exclusions

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

1. Respite Care Services-Out of Home;
2. Companion Care;
3. Host Home;
4. CLS;
5. MIHC;
6. Environmental Accessibility Adaptations (if housing is leased or owned by the provider); or
7. Transportation - Community Access.

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

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

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

Respite Care Services – Out of Home

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

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

Community activities and transportation to and from these activities, which the beneficiary typically engages in are to be available while receiving Respite Care services - out of home.

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

Service Units and Limitations

Respite Care Services - out of home:

1. Service unit is 15 minutes;
2. Respite Care services are limited to 720 hours per beneficiary, per POC year; and
3. Respite Care services cannot be provided in a private residence.

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

Service Exclusions

1. Respite care services-out of home is not a billable waiver service to beneficiaries receiving the following services:
 - a. Shared Living services;
 - b. Host Home services;
 - c. Companion Care services; and
 - d. CLS cannot be provided at the same time on the same day.
2. Respite Care services - out of home cannot be provided in a personal residence; and
3. Payment will not be made for Transportation-Community Access.

Reimbursement

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

Personal Emergency Response System

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

1. Have a demonstrated need for quick emergency back-up;
2. Are able to identify that they are in an emergency situation and then are able to activate the system requesting assistance;
3. Are unable to use other communication systems as the systems are not adequate

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to summon emergency assistance; and

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

The beneficiary may wear a portable "help" button to allow for mobility. The PERS is connected to the person's phone and programmed to signal a response center to secure help in an emergency once the "help" button is activated. The response center is staffed by trained professionals.

PERS services include:

1. The initial installation of the equipment;
2. Training for the beneficiary in the use of the device;
3. Rental of the device/electronic help button;
4. Monthly maintenance fees; and
5. Enhance Services - Mobile Emergency Response System - an on-the-go mobile medical alert system, used in and outside the home:
 - a. This system will have cellular/GPS technology, two-way speakers, and no base station will be required; and
 - b. In addition to the current system that plugs into a landline, a system that uses cellular service may be used and the landline is not required; this system will have a fall detection pendant.

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

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

Service Units and Limitations

1. Service unit comprises initial installation and monthly service;
2. Reimbursement will be made for an installation fee for the PERS unit;
3. Coverage of the PERS is limited to the rental of the electronic device; and

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4. Cell phone service is not included and is not a covered waiver service.

Reimbursement

Reimbursement will be made for a one-time installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS. (See Appendix E for Rate and Billing Code information).

One - Time Transitional Services

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

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

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

1. Non-refundable security deposit;
2. Utility deposits (set-up/deposit fee for telephone service);
3. Purchase of essential furnishings to establish living arrangements, including:
 - a. Bedroom furniture;
 - b. Living room furniture;
 - c. Table and chairs;
 - d. Window blinds;
 - e. Kitchen items (i.e., food preparation items, eating utensils); and
 - f. Bed/bath linens.
4. Moving expenses required to occupy and use a community domicile;

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5. Health and safety assurances (i.e., pest eradication, one-time cleaning prior to occupancy); and
6. Non-refundable security deposits and set-up fees (i.e. telephone, utility, heating by gas) which are required to obtain a lease on an apartment or home.

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

This service shall only be provided by LDH, OCDD with coordination of appropriate entities.

Service Units and Limitations

1. There is a one-time, life time maximum of \$3,000 per beneficiary; and
2. Service expenditures must be prior authorized and tracked by the prior authorization (PA) contractor and are time limited.

Service Exclusions

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

1. Housing;
2. Rent;
3. Refundable security deposits (non-refundable security deposits are not to include rental payments);
4. Household appliances/items that are intended for purely recreational purposes;
5. Furnishings or setting up living arrangements for:
 - a. Residences of any family member;
 - b. Persons receiving Host Home services; or
 - c. Payment for housing or rent.
6. One-Time Transitional services are not available to beneficiaries who are receiving host home services;

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7. One-Time Transitional services are not available to beneficiaries who are moving into a family member's home; and
8. One-Time Transitional services may not be used to pay for furnishings or setting up living arrangements that are owned or leased by a waiver provider.

Environmental Accessibility Adaptations

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

1. Health;
2. Welfare;
3. Safety; and
4. Ability to function with greater independence in the home without which the beneficiary would require additional supports or institutionalization.

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

All environmental accessibility adaptations, for the home and/or vehicle, must:

1. Be included in the beneficiary's POC;
2. Be accepted by the beneficiary;
3. Meet all applicable standards of manufacture, design, and installation;
4. Be fully delivered, installed, and operational; and
5. Be reimbursed in the current POC year in which it was approved.

NOTE: Reimbursement for any environmental accessibility adaptation shall not be authorized until the support coordinator receives written documentation that the job has been completed to the satisfaction of the beneficiary/family.

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

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Home Adaptations

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

1. Bathroom modifications;
2. Ramps;
3. Other adaptations to make the home accessible to the beneficiary;
4. Performance of necessary assessments in addition to occupational therapy/physical therapy evaluations that may be necessary to determine the types of modifications that are necessary;
5. Installation of:
 - a. Ramps and grab-bars;
 - b. Widening of doorways;
 - c. Modification of bathroom facilities; or
 - d. Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the beneficiary.
6. Training the beneficiary and provider in the use and maintenance of the Environmental Adaptation (s);
7. Repair of all equipment and/or devices, including battery purchases and other reoccurring replacement items that contribute to the ongoing maintenance of the adaptation(s); and
8. Standard manufacturer provided service contracts and other warranties from manufactures and providers related to the environmental adaptations.

Place of Service

Home adaptation services are provided at the beneficiary's home and may not be furnished to adapt living arrangements that are owned or leased by waiver providers; and modifications may

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be applied to rental or leased property only with the written approval of the landlord and approval of the LGE.

Service Units and Limitations for Home Adaptation

1. Service unit is determined per item/service;
2. All adaptations must meet all applicable standards of manufacture, design, and installation;
3. Home modification funds are not intended to cover basic construction costs;
4. Waiver funds may be used only to pay the cost of purchasing specific approved adaptations for the home, not for construction costs of additions to the home;
5. Home modification funds may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services;
6. Home modification funds may not include modifications which add to the total square footage of the home except when the additional square footage is necessary to make the required adaptations function appropriately (e.g., if a bathroom is very small and a modification cannot be done without increasing the total square footage, this would be considered an approvable cost);
7. When new construction or remodeling is a component of the service involved, payment for the service is to only cover the difference between the cost of typical construction and the cost of specialized construction for the person with the disability; and
8. Home modification requests with costs exceeding \$20,000 should be sent to the State Office Review Committee (SORC) for review, recommendations, and approval.

Services Exclusions for Home Adaptation

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

1. Flooring (carpet, wood, vinyl, tile, stone, etc.);
2. Roofing installation or repairs, including also covered ramps, walkways, parking areas, etc.;

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3. Air conditioning or heating (solar, electric, or gas; central, floor, wall or window units, heat pump-type devices, furnaces, etc.);
4. Hot tubs;
5. Swimming pools;
6. General home repair and maintenance;
7. Exterior fences or repairs made to any such structures;
8. Interior/exterior walling not directly affected by a modification;
9. Lighting or light fixtures, which are for non-medical use;
10. Furniture;
11. Motion detector or alarm systems for fire, security, etc.;
12. Fire sprinklers, extinguishers, hoses, etc.;
13. Replacement of toilets, septic system, cabinets, sinks, counter tops, faucets, windows, electrical or telephone wiring, or fixtures when not affected by a modification, not part of the installation process, or not one of the pieces of medical equipment being installed;
14. Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.);
15. Repairs or modifications provided to previously installed home modifications not provided under the ROW;
16. Smoke and carbon monoxide detectors;
17. Interior/exterior non-portable oxygen sites; or
18. Whole home (gas/electrical) generators.

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

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

A written, itemized, detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted to the LGE for PA. The LGE must approve the “Environmental Modifications Job Completion Form” (Form-PF-01-010).

Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates from manufacturers. The warranty for labor and installation must cover a period of at least six months.

Vehicle Adaptations

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

Vehicle adaptations may include:

1. The performance of necessary assessments in addition to occupational therapy/physical therapy evaluations to determine the types of modifications that are necessary;
2. A lift or other adaptations to make the vehicle accessible to the beneficiary or to make the vehicle accessible for the beneficiary to drive;
3. Training the beneficiary and provider in the use and maintenance of the adaptation;
4. Repair of all equipment and/or devices, including battery purchases and other reoccurring replacement items that contribute to the ongoing maintenance of the adaptation(s); and
5. Provision of service contracts and other warranties from manufactures and providers related to the vehicle adaptations.

Service Units and Limitations

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

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2. Vehicle modification requests with cost exceeding \$20,000 should be sent to SORC for review recommendations and approval.

Service Exclusions for Vehicle Adaptations

The following vehicle adaptations are excluded:

1. Adaptions to vehicles that are owned or leased by a paid caregiver or by providers of waiver services;
2. Modifications which are of general utility and are not of direct medical or remedial benefit to the beneficiary;
3. Purchase or lease of a vehicle;
4. Regularly scheduled upkeep and maintenance of a vehicle, except for upkeep and maintenance of the modifications;
5. Service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g., extended warranties, extended service contracts); and
6. Car seats.

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

A written, itemized, and detailed bid must be obtained and submitted to the LGE for PA. The LGE must approve the “Environmental Modifications Job Completion Form.” (Form-PF-01-010).

Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates from manufacturers. The warranty for labor and installation must cover a period of at least six months.

Reimbursement

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

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The environmental accessibility adaptation must be accepted by the beneficiary and be fully delivered, installed, and operational in the current POC year in which it was approved. It must be billed for reimbursement within the timely filing guidelines established for Medicaid reimbursement.

Payment will not be authorized until the support coordinator has received written documentation demonstrating that the job has been completed to the satisfaction of the beneficiary. If the adaptation is not accepted by the beneficiary, then OCDD Central Office will request the LGE contact the beneficiary to mediate the issue to a final resolution.

Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates from the manufacturers. The warranty for labor and installation must cover a period of at least 6 months.

Assistive Technology/Specialized Medical Equipment and Supplies

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

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

1. Items that are necessary for life support;
2. Items that are necessary to address physical conditions, along with ancillary supplies;
3. Items that will increase ability to perform ADL;
4. Items that will increase, maintain, or improve ability to function more independently in the home and/or community;
5. Items that will increase the beneficiary's ability to perceive, control, or communicate within their environment;

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6. Equipment necessary to the proper functioning of such items to address physical conditions; and
7. Necessary medical supplies that are not available under the State Plan.

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

AT/SMES provided through the ROW include the following services:

1. Evaluation of the assistive technology needs of a beneficiary, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the beneficiary in the customary environment of the beneficiary in addition to occupational therapy/physical therapy evaluations;
2. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
3. Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for the beneficiary;
4. Training or technical assistance on the use and maintenance of the equipment or device for the beneficiary, or, where appropriate, their family members, guardians, advocates, or authorized representatives of the beneficiary, professionals, or other individuals who provide services to employ, or who are otherwise substantially involved in the major life functions of the beneficiary;
5. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the POC;
6. Provision of service contracts and other warranties from manufactures and providers related to the AT/SMES;
7. Equipment or device repair and replacement of batteries and other reoccurring replacement items that contribute to ongoing maintenance of these devices;

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

8. Technology supports with remote features:
 - a. Mobile Emergency Response System - an on-the-go mobile medical alert system, used in and outside the home. This system will use cellular/GPS technology, two-way speakers, and no base station is required;
 - b. Medication Reminder System- an electronic device programmed to remind individuals to take medications by a ring, automated recording or other alarm. The electronic device may dispense controlled dosages of medication and may include a message back to the center if a medication has not been removed from the dispenser. Requires the ability to self-administer medication with reminder and services face-to-face once per month;
 - c. Monitoring devices, stand alone or intergraded, include all accessories, components, and electronics not otherwise classified. Monitoring feature devices may be interactive audio and video;
 - d. Assessment of home, physical and family environment, to determine suitability to meet the beneficiary's medical needs;
 - e. Purchase of emergency response system; and
 - f. Other equipment used to support someone remotely may include but not limited to: electronic motion door sensor devices, door alarms, web-cams, telephones with modifications (large buttons, flashing lights), devices affixed to wheelchair or walker to send alert when fall occurs, text-to-speech software, intercom systems, tablets with features to promote communication or smart device speakers.

9. Incontinence Supplies including disposable diapers/ briefs, underwear/pull-on, bladder control pads, reusable and disposable under pads, liners, shield guards, disposable and reusable protective underwear, disposable penile wrap and other medically necessary incontinence products for individuals age 21 and greater not covered under Medicaid state plan:
 - a. Does not cover items that have been denied through Durable Medical Equipment (DME) and other programs for lack of medical necessity; and
 - b. To receive incontinence supplies, the beneficiary must have the following:

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- i. Documentation of medical necessity on current 90L;
- ii. Request for incontinence supplies form signed by a physician, physician assistant, or nurse practitioner (NP);
- iii. Prescription from a physician, physician assistant, or NP; and
- iv. PA.

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

Remote Technology Consultation is the evaluation of tech support needs for an individual, including functional evaluation of technology available to address the beneficiary’s needs and support to achieve outcomes identified in the POC.

Requirements

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

Must first access and exhaust items furnished under State Plan.

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

Place of Service

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

Service Limitations and Exclusions

Excluded are those durable and non-durable items that are available under the Medicaid State Plan. Support coordinators shall pursue and document all alternate funding sources that are available to the beneficiary before submitting a request for approval to purchase or lease assistive technology/specialized medical equipment and supplies.

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

1. Assistive technology devices and specialized equipment and supplies that are of general utility or maintenance and items that are not of direct medical or remedial benefit to the beneficiary are excluded from coverage;
2. Any equipment, device, appliance, or supply that is covered and has been approved under the Medicaid State Plan is excluded from coverage;
3. For adults over the age of 20 years, specialized wheelchairs, whether motorized, mobile or travel, are not covered as this is a state plan covered item (DME);
4. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design, and installation;
5. Incontinence supplies annual maximum cost is \$2,500/POC year without exception; and
6. AT/SMES requests with cost exceeding \$20,000 should be sent to SORC for review, recommendations, and approval.

Excluded are those equipment and supplies that are of general utility or maintenance and are not of direct medical or remedial benefit to the beneficiary, such as:

1. Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.);
2. Daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, Q-tips, etc.);
3. Rent subsidy;
4. Food, bed covers, pillows, sheets etc.;
5. Swimming pools, hot tubs etc.;
6. Eye exams;
7. Athletic and tennis shoes;

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8. Automobiles;
9. Van lifts for vehicles that do not belong to the beneficiary or their family;
10. Adaptive toys or recreation equipment (swing set, etc.);
11. Personal computers and software;
12. Exercise equipment;
13. Taxi fares, intra and interstate transportation services, and bus passes;
14. Pagers, including monthly service;
15. Telephones, including mobile telephones and monthly service;
16. Home security systems, including monthly service; and
17. Whole home gas/electrical generators.

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

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

Reimbursement

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

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

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Transportation – Community Access Services

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

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

Place of Service

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

Service Units and Limitations

1. Service unit is “one-way,” limited to no more than three round trips per day with an annual limit of 264 “one-way” units;
2. All trips have to be in accordance with and included in the POC;
3. The beneficiary must be present for the service to be billed;
4. All trips must be clustered together for geographic efficiency;
5. Greater than three trips per day require approval from the Department or its designee;
6. The beneficiary is to utilize free transportation provided by family, neighbors, friends, and community agencies that can provide transportation into the community are to do so without charge;
7. The beneficiary should access public transportation or the most cost-effective method of transport prior to accessing Transportation-Community Access;
8. Transportation-Community Access Services shall not replace transportation services to medically necessary services under the Medicaid State Plan or transportation services provided as a means to get to and from school;

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9. Transportation-Community Access services are not to be used to transport the beneficiary to any day habilitation, pre-vocational, or supported employment services;
10. Transportation-Community Access services may not be provided/billed at the same time on the same day as CLS;
11. Transportation-Community Access are not available to beneficiaries receiving Shared Living Services or Host Home Services; and
12. A provider is limited to providing services to three beneficiaries.

Service Exclusions

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

1. Transportation services to medically necessary services under the State Plan;
2. Transportation services provided as a means to get to and from school; and
3. Transportation services for Day Habilitation, Prevocational Services, or Supported Employment Services.

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

1. Shared Living services;
2. Host Home; or
3. Companion Care.

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

Professional Services

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

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Available professional services include:

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

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

Beneficiaries under the age of 21 years are to access professional services through the EPSDT Program prior to accessing professional services through ROW.

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

The professional service can include:

1. Assessments and/or re-assessments specific to the area of specialty with the goal of identifying status and developing recommendations, treatment, and follow-up;
2. Information to the beneficiary, family, and caregivers, along with other support team members, to assist in planning, developing, and implementing the beneficiary's POC;
3. Training to the beneficiary, family, and caregivers with the goal of skill acquisition and proficiency;
4. Necessary therapy to the beneficiary as indicated in the POC;
5. Consultative services and recommendations as the need arises;

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6. Training and counseling services for natural supports and caregivers in a home setting with the goal of developing and maintaining healthy, stable relationships by providing:
 - a. Emphasis on the acquisition of coping skills by building upon family strengths; and
 - b. Services intended to maximize the emotional and social adjustment and well-being of the individual, family, and caregiver.
7. Providing nutritional services, including dietary evaluation and consultation with individuals or their care provider, which are intended to maximize the individual's nutritional health;
8. Providing therapy to the beneficiary necessary to the development of critical skills as indicated in the POC;
9. Training or therapy to a beneficiary and/or natural and formal supports necessary to either develop critical skills that may be self-managed by the beneficiary or maintained according to the beneficiary's needs;
10. Assistance in increasing independence, participation, and productivity in the beneficiary's home, work, and/or community environments;

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

11. Intervening in a crisis situation with the goal of stabilizing and addressing issues related to the cause(s) of the crisis activities may include:
 - a. Development of support plan(s);
 - b. Training;
 - c. Documentation strategies;
 - d. Counseling;
 - e. On-call supports;
 - f. Back-up crisis supports;
 - g. On-going monitoring; and

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

Service Units and Limitations

- 1. Service unit is 15 minutes; and
- 2. The beneficiary must be present for professional services to be billed.

Services Exclusions

- 1. Private Insurance must be billed and exhausted prior to accessing waiver funds;
- 2. Professional services may only be furnished and reimbursed through ROW when the services are medically necessary, or have habilitative or remedial benefit to the beneficiary;
- 3. Children must access and exhaust services through EPSDT prior to accessing waiver funds; and
- 4. The following activities are not reimbursable:
 - a. Friendly visiting or attending meetings;
 - b. Time spent on paperwork or travel;
 - c. Time spent writing reports and program notes;
 - d. Time spent on the billing of services; and
 - e. Other non-medical reimbursable activities.

Nursing Services

Nursing services are medically necessary services that are ordered by a physician and are provided by a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of a RN within the scope of the state's Nurse Practice Act. Nursing services must be provided by a licensed, enrolled home health agency and requires an individual nursing service plan. Nursing services must be in the beneficiary's POC. Nursing services provided in the ROW are an

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extension of nursing services provided through the Home Health program covered under the Medicaid State Plan.

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

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

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

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

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

Service Units and Limitations

1. Service unit is 15 minutes;
2. Assessment services are offered on an individual basis only and must be performed by a RN;
3. Health related training/education service is the only nursing service which can be provided to more than one beneficiary simultaneously. In this instance, the cost of the service is allocated equally among all beneficiaries receiving the health-related training/education;
4. Nursing services will not be reimbursed when the beneficiary is in a hospital or other institutional setting;

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5. Both the beneficiary and the nurse must be present in order for the provider to bill for this service; and
6. The following activities are not reimbursable:
 - a. Friendly visiting or attending meetings;
 - b. Time spent on paperwork or travel;
 - c. Time spent writing reports and program notes;
 - d. Time spent on the billing of services; and
 - e. Other non-medical reimbursable activities.

Services Requirements

1. Nursing services are secondary to EPSDT services for beneficiaries under the age of 21 years;
2. Beneficiaries under the age of 21 years have access to nursing services (home health and extended care) under the Medicaid State Plan; and
3. Adults have access only to Home Health nursing services under the Medicaid State Plan. Beneficiaries must access and exhaust all available Medicaid State Plan services prior to accessing ROW nursing services.

Place of Service

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

Supported Employment

Supported Employment (SE) services are services and supports provided to individuals with disabilities to support them in typical jobs in standard business, industrial, and community environments. SE services must be provided in a manner that promotes workplace integration and encourages interaction between employees with and without disabilities, as well as customers.

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SE services are broken into two overarching categories:

1. Individual SE (1:1); and
2. Group Employment (1:5-8).

Individual Supported Employment

Individual SE services are broken into separate services designed to support a beneficiary throughout the entire employment process for competitive integrated employment.

Individual SE services expand the available options for a beneficiary who requires services to achieve and maintain integrated, competitive employment in the community. These services include:

1. Work based learning experience assessment;
2. Job development and job placement;
3. Initial job support and job stabilization;
4. Extended job supports;
5. Follow along job supports; and
6. Follow along job supports – virtual delivery.

Competitive integrated employment refers to work performed, either on a full time or part time basis, in a community setting where a beneficiary receives compensation at or above minimum wage, but not less than the customary wage and level of benefits paid by an employer for the same or similar work performed by individuals without disabilities. The company employing the beneficiary usually pays the person directly.

Integration extends beyond simply being physically present at a work site. An integrated work setting is a job site in the community where individuals with disabilities work alongside people without disabilities, perform typical job duties, share work breaks/break areas, and other social activities that may occur outside of work hours.

Unpaid natural supports such as co-workers, family, friends, and/or other comparable services, as appropriate, may be identified and used to support a beneficiary to maintain employment instead of or in addition to follow along supports. Beneficiaries who have the most significant support needs may require long-term employment supports to successfully maintain a job due to the

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ongoing nature of the beneficiary's support needs, changes in life situations or evolving and changing job responsibilities, and where natural supports would not meet this need.

The individual SE process may also be used for customized employment or self-employment. However, there are no waiver services that pay for the start-up costs of a business. The beneficiary should obtain assistance through vocational rehabilitation services or other programs. The employment provider may assist the beneficiary in locating funding. Waiver services may be used to support the beneficiary in learning the process, the same as for an individual job placement.

SE services do not support a beneficiary in a volunteer job/position.

The use of the EVV system is mandatory for all SE services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS).

Individual SE is conducted in a variety of settings, in particular at work sites in which persons without disabilities are employed. When services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by beneficiaries receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Prior to receiving individual SE services, the beneficiary must apply for and exhaust any similar services available through vocational rehabilitation services, Louisiana Rehabilitation Services (LRS), or the Individuals with Disabilities Education Act (IDEA) if the beneficiary is still attending high school.

The following circumstances allow a beneficiary to use waiver services first:

1. Beneficiary applied for and was denied LRS services or was placed into 'extended review services', therefore an eligibility was not made;
2. Beneficiary was determined eligible but was placed on a 'waiting list'; or
3. Beneficiary was determined eligible but did not have an individual plan for employment (IPE) developed within 91 days.

If one of the instances listed above applies, documentation must be placed in the beneficiary's file and waiver services can be authorized. We will not prevent someone from finding employment in a timely manner.

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There must be documentation in the beneficiary's file that individual SE services are not available from programs funded under the Rehabilitation Act of 1973, the IDEA, or Medicaid State Plan, if applicable.

Work Based Learning Experience Assessment

The 'Work Based Assessment' phase is to allow the beneficiary opportunities to 'try out' jobs that have been identified in the areas of interest as expressed by the beneficiary after completing job exploration and discovery. Up to three areas of interest should be in the 'Individual Profile' that is on file. The 'Individual Profile' is a product of the 'Discovery and Exploration' phase completed in the 'Community Career Planning (CCP)' service, which is addressed in the 'Prevocational Services' section below. It is not a requirement to complete the CCP service; therefore, an 'Individual Profile' may not be on record. If a beneficiary has not established a job interest, the provider may spend time with the beneficiary to discover the areas of interest before identifying jobs in the community for the 'Work Based Assessment' phase.

After the assessment phase is completed, a beneficiary will work with the employment specialist to determine the specific job or area of interest before the 'Job Development and Job Placement' phase begins.

Documentation Requirements

1. Provider must complete the 'Work Based Assessment Form' for each assessment that is completed. Up to three assessments are allowed;
2. Provider must provide a copy of the 'Work Based Assessment Form' to the support coordinator and the LGE so the support coordinator can authorize payment in the LaSRS; and
3. If an Individual Profile is not available, the provider must also complete the 'Work Based Assessment Profile Form' and provide a copy to the support coordinator and LGE at the same time the 'Work Based Assessment Form' is submitted.

Place of Service

This service is delivered in the community at various business locations with both the employment specialist and beneficiary present. The assessments should be completed in businesses/companies related to the beneficiary's interests.

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Restrictions with Other Services

Each assessment should be at least 3 hours on each job site where the assessment is completed.

This service cannot be billed at the same time on the same day as other services, with the exception of CLED, MIHC and companion care, if applicable.

Staffing Ratio

This service is completed in a 1:1 ratio.

Service Limits

1. The standard unit is a ‘fee for each assessment’ completed;
2. Up to three assessments are allowed per POC year; and
3. Use of the EVV system is mandatory for all SE services. The EVV system requires the electronic check in/out in the LaSRS.

Transportation

Transportation is included in the rate.

Provider Qualifications

The staff who delivers this service must meet the following requirements:

1. Possess and maintain a 40-hour SE training certificate of completion from an approved program;
2. Maintain this certificate by completing 15 hours of employment related training and providing documentation to the LGE office by December 31st each year; and
3. Provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services (HCBS)*, HCBS Settings Rule requirements, and HCBS guidance as provided.

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Job Development and Job Placement

The 'Job Development and Job Placement' phase is used to develop a successful job match for the beneficiary and assist the beneficiary with obtaining the job and making the initial placement on the job.

Job development requires the employment specialist to make contact with prospective employers to determine if they have needs that match the results of the 'Individual Profile' developed in the 'CCP' phase and/or 'Work Based Assessments' and to facilitate the hiring of the beneficiary if it is a good match.

Once a beneficiary has accepted a job and there is a start date, the 'Job Placement Form' should be completed as the beneficiary is ready for the 'Initial Job Supports and Job Stabilization' phase.

Documentation Requirements

1. Each time the employment specialist contacts an employer, an entry on the 'Job Development Employer Contact Activities Log' should be made;
2. Provider must provide a copy of the 'Job Development Employer Contact Activities Log' to the support coordinator and LGE for each month that the job development is taking place; and
3. The 'Job Placement Form' should be completed once the beneficiary has a start date for their job and a copy should be provided to the support coordinator and LGE office.

Place of Service

This service takes place in the community in various businesses where the beneficiary has shown interest for employment. The beneficiary does not have to be present for this service to take place and be billed.

Restrictions with Other Services

This service may be billed at the same time as other services, as the beneficiary does not have to be present for this service to occur.

Staffing Ratio

This service is completed in a 1:1 ratio.

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Service Limits

1. The standard unit is a 15-minute increment;
2. 480 units are allowed per POC year; and
3. Use of the EVV system is mandatory for all SE services. The EVV system requires the electronic check in/out in the LaSRS.

Transportation

1. Transportation is a separate billable service and may be billed on the same day as this service;
2. The transportation rate is billed as a flat rate fee for each day this service is delivered;
3. Provider must provide transportation at least one way in order to be reimbursed;
4. Transportation cannot be provided at the same time another service is being delivered, with the exception of CLED (if applicable);
5. The staff providing transportation cannot also be providing another service at the same time as providing transportation;
6. In order to bill for transportation, the provider agency must provide the service, or may subcontract; regardless of who provides the service, they must meet the HHS regulations for transportation. The provider is ultimately responsible; and
7. Use of the EVV system is not mandatory for this service; however, **transportation must be entered into the LaSRS to be reimbursed.** If EVV is not used, the provider is responsible for preparing and retaining documentation that identifies the person transporting, the person transported, the pick-up time and location, and the drop off time and location for each single transportation service.

Provider Qualifications

The staff who delivers this service must meet the following requirements:

1. Possess and maintain a 40-hour SE training certificate of completion from an approved program;

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2. Maintain this certificate by completing 15 hours of employment related training and providing documentation to the LGE office by December 31st each year; and
3. Provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

Initial Job Support and Job Stabilization

The ‘Initial Job Support and Job Stabilization’ phase is to provide the beneficiary with the initial job support at their new job, or job coaching, to allow the beneficiary time to learn and become adapted to their job duties and expectations. The employment specialist will continue to work with the beneficiary to determine what is needed for the beneficiary to be as independent on the job as possible. The job coach may implement various strategies such as, assistive technology, and other employment supports found to work for the beneficiary. Natural supports that will allow the beneficiary to become less dependent on the job coach and still complete the job duties should be explored. The beneficiary may require other support not necessarily related to doing their job, but may be provided through the beneficiary’s DSP at the job site.

The employment specialist will determine the amount of ongoing support the beneficiary will require in order to maintain the job once it is established that the beneficiary has understood the expectations of the job, is able to fulfill the expectations and demands of the job at the beneficiary’s highest independence level, including using natural supports, AT, or other employment supports. The job coach will have supported the beneficiary through the initial phase of learning the job and adjusting to the demands of the job and believes the beneficiary is stable on their job. At this time, the employment specialist will make a professional recommendation of the supports required and the next phase needed for the beneficiary to maintain the job, to the team.

The beneficiary may require the use of the ‘Extended Job Supports’ service if it’s been determined that the beneficiary still requires the support of a job coach on the job more frequently than is allowed through the ‘Follow Along Job Supports’ service. The next phase determination will vary by beneficiary and will be discussed in a team meeting.

Documentation Requirements

1. The employment specialist will complete the ‘Initial Job Support Time Log’ during the times job coaching or meetings with the employer and staff are taking place, and submit the log for each month that job coaching is taking place and submit it to the support coordinator and LGE;

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2. The employment specialist will complete the ‘Initial Job Support Monthly Report Form’ each month that job coaching is taking place and submit to the support coordinator and LGE;
3. The employment specialist will complete ‘Natural Supports Plan’ if able to be established and submit to the support coordinator and LGE; and
4. The employment specialist will complete the ‘Job Stabilization Report’ and submit it to the support coordinator and the LGE, and request a team meeting from the support coordinator to discuss the next phase of the SE process.

Place of Service

This service takes place on the job in the community.

Restriction with Other Services

This service may not be billed at the same time on the same day as other services, with the exception of CLED, MIHC and companion care, if applicable.

Staffing Ratio

This service is completed in a 1:1 ratio.

Service Limits

1. Standard unit is a 15-minute increment;
2. 1,920 units are allowed per POC year; and
3. Use of the EVV system is mandatory for all SE services. The EVV system requires the electronic check in/out in the LaSRS.

Transportation

1. Transportation is a separate billable service and may be billed on the same day as this service;
2. The transportation rate is billed as a flat rate fee for each day this service is delivered;
3. Provider must provide transportation at least one way in order to be reimbursed;

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4. Transportation cannot be provided at the same time another service is being delivered, with the exception of CLED (if applicable);
5. The staff providing transportation cannot also be providing another service at the same time as providing transportation.
6. In order to bill for transportation, the provider agency must provide the service, or may subcontract; regardless of who provides the service, they must meet the HHS regulations for transportation. The provider is ultimately responsible; and
7. Use of the EVV system is not mandatory for this service; however, **transportation must be entered into the LaSRS to be reimbursed.** If EVV is not used, the provider is responsible for preparing and retaining documentation that identifies the person transporting, the person transported, the pick-up time and location, and the drop off time and location for each single transportation service.

Provider Qualifications

The staff who delivers this service must meet the following requirements:

1. Possess and maintain a 40-hour SE training certificate of completion from an approved program;
2. Maintain this certificate by completing 15 hours of employment related training and providing documentation to the LGE office by December 31st each year; and
3. Provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

Extended Job Supports

Extended job supports service is provided to a beneficiary who is stable on a job, but still requires paid job supports in order to complete their job duties, as noted on the 'Job Stabilization Report' at the end of the team meeting at the end of the 'Initial Job Support and Job Stabilization' phase. The purpose of this phase is to allow additional job coaching supports to the beneficiary with the plan to increase their independence level in completing their job duties. This service is not required in the SE process, but is available to those beneficiaries who require the additional time in order to become more independent in completing their job duties. The amount of support will vary depending on the support needs of the beneficiary. The frequency of this service may change and should be evaluated on an ongoing basis by the employment specialist.

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The goal is to support the beneficiary to be as independent as possible on the job. The employment specialist should continue to try to increase the beneficiary's independence in their job by implementing new strategies. The team should be included as needed to discuss new strategies and get feedback.

This service may also be utilized for someone who was receiving follow along job supports service and experienced a change in their support needs on the job, such as learning new job duties, a promotion, or something that has changed with the beneficiary that has resulted in the need of additional supports that aren't currently met through the follow along job supports service.

Documentation Requirements

1. The employment specialist should make an entry on the 'Extended Job Supports Time Log' each time job coaching is taking place;
2. The employment specialist should turn in a copy of the completed 'Extended Job Supports Time Log' to the support coordinator and LGE for each month the extended job support is taking place;
3. The employment specialist should complete the 'Extended Job Supports Monthly Report Form' and submit a copy to the support coordinator and the LGE each month that extended job support is taking place; and
4. The beneficiary's quarterly meeting should include a discussion about the progress made over the last three months.

Place of Service

This service takes place on the job in the community.

Restrictions with Other Services

This service may not be billed at the same time on the same day as other services, with the exception of CLED, MIHC, and companion care, if applicable.

Staffing Ratio

This service is completed in a 1:1 ratio.

Service Limits

1. Standard unit is a 15-minute increment;

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2. 1,920 units are allowed per POC year; and
3. Use of the EVV system is mandatory for all SE services. The EVV system requires the electronic check in/out in the LaSRS.

Transportation

1. Transportation is a separate billable service and may be billed on the same day as this service;
2. Transportation rate is billed as a flat rate fee for each day this service is delivered;
3. Provider must provide transportation at least one way in order to be reimbursed;
4. Transportation cannot be provided at the same time another service is being delivered, with the exception of CLED (if applicable);
5. Staff providing transportation cannot also be providing another service at the same time as providing transportation;
6. In order to bill for transportation, the provider agency must provide the service or may subcontract; regardless of who provides the service, they must meet the HHS regulations for transportation. The provider is ultimately responsible; and
7. Use of the EVV system is not mandatory for this service; however, **transportation must be entered into the LaSRS to be reimbursed**. If EVV is not used, the provider is responsible for preparing and retaining documentation that identifies the person transporting, the person transported, the pick-up time and location, and the drop off time and location for each single transportation service.

Provider Qualifications

The staff who delivers this service must meet the following requirements:

1. Possess and maintain a 40-hour SE training certificate of completion from an approved program;
2. Maintain this certificate by completing 15 hours of employment related training and providing documentation to the LGE office by December 31st each year; and

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3. The provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

Follow Along Job Supports

The need for ‘Follow Along Job Supports’ service is determined once a beneficiary has stabilized on the job either after the ‘Initial Job Support and Job Stabilization’ service or the ‘Extended Job Supports’ service. ‘Follow Along Job Supports’ services consist of a ‘check-in’ by the employment specialist at the frequency that was determined during the team meeting discussion at the end of the previous phase. The check-in may include the employment specialist meeting with the beneficiary and/or employer to assure a beneficiary is continuing to complete the job duties and meeting the requirements of the job. It may also include a check on the natural supports, the DSP support, and any other employment supports that the beneficiary is utilizing. This service may be utilized to provide short term job coaching, if the beneficiary is needing support to learn a task or any other need that has arisen that can be accomplished short term. The employment specialist should ensure that no additional supports are needed by the beneficiary in order to continue success on the job.

If it is determined that the beneficiary requires employment supports that cannot be provided during the current ‘Follow Along Job Supports’ service, the employment specialist will contact the support coordinator and call a team meeting.

Documentation Requirements

At the time of the follow along visit, the employment specialist should complete the ‘Follow Along Job Supports Progress Report’ and a copy should be provided to the support coordinator and the LGE office.

Place of Service

This service takes place on the job and in the community.

Restriction with Other Services

This service may not be billed at the same time on the same day as other services with the exception of CLED, MIHC, and companion care, if applicable.

Staffing Ratio

This service is completed in a 1:1 ratio.

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Service Limits

1. Standard unit is a fee for service;
2. 48 units are allowed per POC year; and
3. Use of the EVV system is mandatory for all SE services. The EVV system requires the electronic check in/out in the LaSRS.

Transportation

1. Transportation is a separate billable service and may be billed on the same day as this service;
2. If the provider is transporting the beneficiary to/from their individual community job, even on days that the provider is not delivering the service, the provider may bill for transportation. To do this, the POC must include H2026 U1 and T2002;
3. Provider must keep a record of the transports;
4. Transportation rate is billed as a flat rate fee for each day this service is delivered;
5. Provider must provide transportation at least one way in order to be reimbursed;
6. Transportation cannot be provided at the same time as another service, with the exception of CLED (if applicable);
7. Staff providing transportation cannot also be providing another service at the same time as providing transportation;
8. In order to bill for transportation, the provider agency must provide the service or may subcontract; regardless of who provides the service, they must meet the HHS regulations for transportation. The provider is ultimately responsible; and
9. Use of the EVV system is not mandatory for this service; however, **transportation must be entered into the LaSRS to be reimbursed**. If EVV is not used, the provider is responsible for preparing and retaining documentation that identifies the person transporting, the person transported, the pick-up time and location, and the drop off time and location for each single transportation service.

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Provider Qualifications

The staff who delivers this service must meet the following requirements:

1. Possess and maintain a 40-hour SE training certificate of completion from an approved program;
2. Maintain this certificate by completing 15 hours of employment related training and providing documentation to the LGE office by December 31st each year; and
3. The provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

Follow Along Job Supports – Virtual Delivery

The need for ‘Follow Along Job Supports - Virtual Delivery’ service is determined once a beneficiary has stabilized on the job either after the ‘Initial Job Support and Job Stabilization’ service or the ‘Extended Job Supports’ service. ‘Follow Along Job Supports’ services, consists of a ‘check-in’ by the employment specialist at the frequency that was determined during the team meeting discussion at the end of the previous phase. The check-in is delivered virtually and includes the employment specialist meeting with the beneficiary and/or employer to ensure a beneficiary is continuing to complete the job duties and meeting the requirements of the job. It may also include a check on the natural supports, the DSP support, and any other employment supports that the beneficiary is utilizing. This service may be utilized to provide short term job coaching if the beneficiary is needing support to learn a task or any other need that has arisen that can be accomplished short term. The employment specialist should ensure that no additional supports are needed by the beneficiary in order to continue success on the job.

If it is determined that the beneficiary requires employment supports that cannot be provided during the current ‘Follow Along Job Supports’ service, the employment specialist will contact the support coordinator and call a team meeting.

Providers will ensure that the beneficiary understands the guidelines for participation in a virtual service delivery, Health Insurance Portability and Accountability Act (HIPAA), and the use of the technology. Written instructions and guidelines will be provided to the beneficiary on those items.

When using virtual delivery, providers are expected to follow these guidelines:

1. Confidentiality still applies for services delivered through virtual delivery. The session must not be recorded without consent from the beneficiary;

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2. Develop a back-up plan (e.g., phone number where beneficiary can be reached) to restart the session or to reschedule it, in the event of technical problems;
3. Verify beneficiary's identity;
4. Providers need the consent of the beneficiary prior to initiating a virtual service with the beneficiary;
5. The beneficiary must be informed of all persons who are present and the role of each person;
6. The beneficiary may refuse services delivered through virtual delivery; and
7. It is important for the provider, the beneficiary, and the employer to be in a quiet, private space that is free of distractions during the session.

The beneficiary and employer will be instructed on the following:

1. Locating a space that allows for privacy while participating in the virtual delivery of the service;
2. Turning the camera off and muting the session if the beneficiary leaves the room while participating in the session, or if someone who is not part of the session enters the location;
3. Ensuring the beneficiary has access to technology and the operation of the technology that is required to participate in the virtual delivery of this service, including setting up and utilizing the specific format. The provider will also provide written instructions to the beneficiary/employer; and
4. Scheduling a meeting with the employment specialist.

The beneficiary's need for hands on/physical assistance on the job will already be established therefore, if the beneficiary requires hands on assistance, someone will be present to provide assistance to the beneficiary. If the need for virtual delivery of job coaching services arises, a process will be in place with the support worker and the job coach in order for the beneficiary to receive the assistance required on the job. However, both services will not be billed at the same time.

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Documentation Requirements

1. Must utilize some type of format that allows for face-to-face interaction between those participating in the meeting, including the beneficiary, provider, and employer (if applicable); and
2. At the time of the Follow Along visit, the employment specialist should complete the 'Follow Along Job Supports Progress Report' and provide a copy to the support coordinator and the LGE office.

Place of Service

This service takes place virtually with the beneficiary and/or employer.

Restrictions with Other Services

This service may not be billed at the same time on the same day as other services, with the exception of CLED, MIHC, and companion care, if applicable. The choice between virtual delivery and in person follow along job support services must be made. Both services cannot be on the POC at the same time.

Staffing Ratio

This service is completed in a 1:1 ratio.

Service Limits

1. Standard unit is a 15 minute increment;
2. 240 units are allowed per POC year; and
3. Use of the EVV system is mandatory for all SE services. The EVV system requires the electronic check in/out in the LaSRS.

Transportation

Transportation is not allowed for virtual delivery.

Provider Qualifications

The staff who delivers this service must meet the following requirements:

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1. Possess and maintain a 40-hour SE training certificate of completion from an approved program;
2. Maintain this certificate by completing 15 hours of employment related training and providing documentation to the LGE office by December 31st each year; and
3. The provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

Group Employment

Group employment services are provided in regular business, industry, and community settings for groups of five to eight beneficiaries with disabilities. SE group services must be provided in a manner that promotes integration into the workplace and interaction with coworkers without disabilities in those workplaces and customers. Provider owned businesses should be operated as a typical business. Beneficiaries should not be working inside of a provider agency where other services are being delivered.

The outcome of this service could be sustained paid employment and work experience leading to further career development and individual integrated community employment for which a beneficiary is compensated at or above minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Group Employment is not a required service. A beneficiary can choose to leave group employment at any time and pursue individual employment if desired.

Group employment does not include:

1. Paid work inside of a provider facility; or
2. Volunteer work.

NOTE: SHELTERED WORK, WHICH IS DEFINED AS WORK INSIDE OF A PROVIDER BUILDING WHERE OTHER SERVICES ARE DELIVERED AND BENEFICIARIES ARE PAID A SUBMINIMUM WAGE, IS NO LONGER ALLOWED.

Group employment services may be authorized when a beneficiary has chosen to work for a business in the community or in a provider-owned business, so long as it's not attached to the building where other services are delivered, when the following occurs:

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1. The waiver beneficiary has had documented conversations about their options for employment and it is documented that the beneficiary has chosen to work in the job and it is in the best interest of the beneficiary;
2. The waiver beneficiary earns at least minimum wage and/or the going rate for the job for people without disabilities and same benefits as people without disabilities;
3. The waiver beneficiary has the same or similar interactions and job duties with the public as people without disabilities in this job;
4. The waiver beneficiary participates in a quarterly discussion about job satisfaction and individual job opportunities in the community;
5. The waiver beneficiary has an individual job description on file; and
6. A person without a disability could be hired for the same job and efforts to hire people without disabilities are made in order to integrate the mobile crew.

In addition to the items listed above, if the business is a provider owned/operated business (i.e. thrift store, bakery, restaurant, etc.) the following must occur:

1. The business must operate as a typical business in the community that provides a service to the community and not one 'created' to give a beneficiary a job; (i.e. license to operate, etc.);
2. The building in which the business operates must be a separate physical location from the rest of the provider building and cannot coexist where other services, such as onsite day habilitation, are delivered; and
3. Members of the public are the primary customers who utilize the services of the business.

Career planning may be included as part of this service as well so that beneficiaries can further plan for individual employment. However, there is a CCP service that may be utilized.

NOTE: For beneficiaries choosing group employment services, the beneficiary does not have to apply for LRS, as LRS does not fund group employment.

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Place of Service

This service takes place in the community in various businesses and industries. This service may be mobile and move about the community, stationary in a business or industry, or a provider owned/operated business.

Restrictions with Other Services

This service may not be billed at the same time on the same day as other services with the exception of CLED, MIHC and companion care, if applicable.

Staffing Ratio

One staff to five to eight beneficiaries (1:5-8).

Service Limits

1. Standard unit is a 15-minute increment;
2. The ROW budget determines the limits; and
3. Use of the EVV system is mandatory for all SE services. The EVV system requires the electronic check in/out in the LaSRS.

Transportation

1. Transportation rate is a flat rate fee for each day this service is delivered;
2. Provider must provide transportation at least one way in order to be reimbursed;
3. Transportation is a separate billable service and may be billed on the same day as this service;
4. Transportation between job sites is part of the service delivery;
5. Transportation cannot be provided at the same time that another service is being delivered to the beneficiary, with the exception of CLED, MIHC or companion care (if applicable);
6. The staff providing transportation cannot also be providing another service at the same time as providing transportation;

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7. Use of the EVV system is not mandatory for this service; however, **transportation must be entered into the LaSRS to be reimbursed.** If EVV is not used, the provider is responsible for preparing and retaining documentation that identifies the person transporting, the person transported, the pick-up time and location, and the drop off time and location for each single transportation service; and
8. Transportation may be billed in the following circumstances:

First Transportation Starts	First Transportation Ends	Second Transportation Starts	Second Transportation Ends
Beneficiary’s home or pickup location	Provider agency building	Provider agency building	Beneficiary’s home or pickup location
Beneficiary’s home or pickup location	At beginning of first job location or community location (does not go to provider building)	At end of last job location or community location	Beneficiary’s home or pickup location (does not go to provider building)

Provider Qualifications

The supervisory staff who delivers this service must meet one of the following sets of requirements:

1. Possess and maintain a 40-hour SE training certificate of completion from an approved program;
2. Maintain this certificate by completing 15 hours of employment related training and providing documentation to the LGE office by December 31st each year; and
3. Provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

OR

1. Be licensed as an adult day care provider by LDH with the Provider Type 98 module;
2. Group employment supervisor receives 15 hours of employment related training annually and provides proof to the LGE office by December 31st each year; and

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3. Provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

Prevocational Services

The overarching service title of ‘Prevocational’ are services designed to create a path to integrated, individual, community employment, in typical businesses, for which a beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Good candidates for all prevocational services may include, but are not limited to, beneficiaries who have never worked, beneficiaries who have only worked in ‘sheltered employment’, beneficiaries who have worked as part of a group model, or beneficiaries who are unsure of what career path they want to choose and need to explore further options. The beneficiary may or may not be employed or may currently be employed and wanting to change careers.

This service is not a required pre-requisite for individual SE services and at any time during this service, one may choose to leave this service to seek employment or because they are no longer interested in working. The outcome of this service should be the creation of an individual career profile that will provide valuable information for the next phase of the career path.

This service should be delivered in practical situations in the community, including businesses, job centers, and/or in conjunction with LRS.

Examples of career planning activities include, but are not limited to, the following:

1. Self-exploration activities that help the beneficiary become aware of their interests, skills, and values that can help guide the career exploration/development;
2. Vocational assessments used to further develop the career goal;
3. Career exploration activities that help the beneficiary learn how to identify career and life goals that are consistent with their interests, skills and values. It also involves opportunities to learn about the skills and qualities required to be successful in various careers and the education and training needed to pursue the career;
4. Volunteering in the community in the areas identified in career exploration activities. This will help to further define a career;

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5. Ongoing career counseling discussions with the beneficiary to help them answer questions they may have or to assist them in any aspect of defining a career goal;
6. Benefits planning completed by a Certified Work Incentive Coordinator (CWIC) to assist the beneficiary in answering any questions regarding Social Security benefits and working;
7. Financial literacy intended to assist the beneficiary in gaining skills and knowledge in the area of their personal finances, which will help them in making more cost-conscious decisions;
8. Assistive technology assessments as needed to enhance a beneficiary's employability;
9. Job shadowing work-based learning, which allows beneficiaries to 'shadow' someone who works in a particular area of interest for a short period of time to gain a better understanding of what the duties are of a specific type of job;
10. Tours of businesses and meetings to learn about what businesses do and career opportunities. This work-based learning allows beneficiaries to meet with employers in specific businesses to find out more about a business that they may be interested in working;
11. Internship work-based learning, which allows beneficiaries to secure internships (either paid or unpaid) in a business in order to learn more in depth aspects of the particular job they are interested in doing;
12. Apprenticeship work-based learning, which allows beneficiaries to secure apprenticeships that will help them develop skills in a particular area and further define a career goal; and
13. Any other activities that may assist the beneficiary in increasing their knowledge in areas that can assist the beneficiary in making decisions, which leads to an employment goal and career path.

Every beneficiary would benefit from volunteering in the community to gain valuable experience in the career path determination. Volunteering offers a beneficiary, especially someone who has never worked, an opportunity to gain insight into being a responsible employee and deciding the type of job they desire. It also gives them valuable knowledge, skills, and experience to add to their resume. Volunteer activities are to be provided under the current guidelines of the United States Fair Labor Standards Act.

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All prevocational service activities are time limited to one year, with a targeted service for beneficiaries who think they want to become employed in an individual job in the community but may need additional information and experiences in order to determine such things as their areas of interests for work, skills, strengths, and conditions needed for successful employment.

Assistance with personal care may be a component of all prevocational services, but may not comprise the entirety of the service.

Under the service umbrella of ‘Prevocational’, there are two distinct services that may be delivered during the same day in order to support the beneficiary in their career discovery path. The goal is to support the beneficiary in creating a career profile that will further their goal of individual employment. Beneficiaries should be involved in making choices and guiding the inclusion of new activities in their job discovery process. Discussions should be ongoing to ensure that the beneficiary is receiving the supports they need to do develop the profile to assist in going to work.

The two services available under the overarching service title of ‘Prevocational’ are described below.

Community Career Planning

CCP is an individualized, person-centered, comprehensive service that assists the beneficiary in establishing their path to obtain individual, competitive, integrated employment in the community. The outcome of this service is to create an ‘Individual Career Profile’ that can be utilized to create their employment plan. CCP services may be provided in a variety of settings including home visits conducted as part of individual discovery and getting to know the beneficiary in their day-to-day life.

Career planning services are intended to use the person-centered planning process to discover the various interests, skills, and general information about each beneficiary that will assist in developing a path to employment in the community. Based on the person-centered planning, activities should be tailored for each beneficiary to prepare them for paid employment in the community.

CCP services should be delivered in the community, in practical situations, alongside people without disabilities who may be exploring their career path as well.

Services should be delivered in typical businesses and industries or in typical agencies that provide career resources/training activities.

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Onsite Prevocational

Onsite prevocational services, also referred to as ‘onsite career planning’ services, are intended to support the beneficiary in developing general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.

Onsite prevocational services could consist of activities such as:

1. Virtual job related classes/workshops;
2. Making contact with businesses via phone or email that might have opportunities for internships, mentoring programs, etc.;
3. Research via the internet for opportunities to volunteer positions;
4. Preparing/planning for job related activities; and
5. Development of an ‘Individual Career Profile’ for each beneficiary.

Onsite career planning services should consider the CCP services and should work together to accomplish the goals set forth.

Onsite Prevocational – Virtual Delivery

Onsite prevocational services may be delivered virtually. Virtual service delivery is an option during times that the beneficiary is unable to attend in person (i.e. medical issues/surgery, an emergency, or when the beneficiary chooses to not attend in-person for personal reasons). The beneficiary should be independent or have natural supports, as this service cannot be billed at the same time as another service. The beneficiary must have the means necessary to participate in the virtual service (i.e., laptop, tablet, etc.).

There is not a predetermined percentage of time that virtual delivery of services will occur participation in this delivery method is an individual choice.

Virtual delivery is not the preferred method as beneficiaries are encouraged to participate in the community through either onsite prevocational or CCP services and are offered these options as well. The support coordinator and the service providers will include a discussion about virtual delivery with each beneficiary. Virtual delivery will only be included in the POC if chosen by the beneficiary.

Prior to the beginning of virtual delivery, the following in-person visits are required:

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1. An initial assessment of the beneficiary and their home to determine if it is feasible; and
2. HIPAA compliance training prior to beginning virtual delivery.

Providers will receive written instructions on the delivery of virtual services based on the HIPAA compliance officer's instructions.

When using virtual delivery, providers will follow these guidelines:

1. Confidentiality still applies for services delivered through virtual delivery. The session must not be recorded without consent from the beneficiary or authorized representative;
2. Develop a back-up plan (e.g., phone number where beneficiary can be reached) to restart the session or to reschedule it, in the event of technical problems;
3. Develop a safety plan that includes at least one emergency contact and the closest ER location, in the event of a crisis;
4. Verify beneficiary's identity, if needed;
5. Providers need the consent of the beneficiary and the beneficiary's authorized representative if applicable (and their contact information) prior to initiating a virtual delivery of a service with the beneficiary;
6. The beneficiary must be informed of all persons who are present and the role of each person;
7. Beneficiaries may refuse services delivered virtually; and
8. It is important for the provider and the beneficiary to be in a quiet, private space that is free of distractions during the session.

Providers will ensure that beneficiaries understand the guidelines for participation in a virtual service delivery and HIPAA. Written instructions and guidelines will be provided to each beneficiary.

Beneficiaries and natural supports will be instructed on the following:

1. Finding a space that allows for privacy while participating in the service;

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2. Turning the camera off and muting the session if they leave the room while participating in the session, or if someone who is not part of the group comes into the room; and
3. Using the technology required to participate in the virtual delivery of day habilitation, including how to utilize the specific format, signing in and out, etc. The provider will also provide written instructions to the beneficiary.

To ensure that virtual delivery of this service facilitates community integration, the provider agency will continue to incorporate already established community partners into the virtual delivery of the service. For instance, if the beneficiary typically attends a career exploration class in the community with community participation occurring, the beneficiary will join via a face-to-face format virtually and therefore still be included in the meeting. Providers will also seek opportunities for beneficiaries to join community online groups in a face-to-face format and seek out such activities as career preparation, mock interview sessions, etc. Through virtual delivery of this service, beneficiaries can continue to interact with their friends and community connections during the times when the beneficiary is not participating in person, and will allow the beneficiary not to miss opportunities for inclusion.

If the beneficiary is able to be unsupported during this service, an existing protocol is in place for the beneficiary if a health and safety issue arises during this virtual service. The provider agency staff, who is conducting the virtual delivery of this service, will be able to support the beneficiary through any health and safety situation that might arise during the virtual delivery of prevocational services. If the beneficiary is participating in virtual services with the assistance of natural supports, the natural supports will ensure the health and safety of the beneficiary.

All virtual delivery of onsite prevocational services must be on the approved POC.

Minimum Requirements for virtual delivery:

1. Must utilize a virtual format that allows for face-to-face interaction;
2. Must utilize EVV to check in and out of virtual delivery; and
3. Must utilize an approved activity log to track the days, times and activities that the beneficiary is using virtual delivery.

Prevocational services is not a requirement to find individual employment, but rather a tool to assist in the career path. If at any point the beneficiary has decided that individual employment is not their end goal, the beneficiary should be referred to their support coordinator and be given the option to choose other day and/or employment services.

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The outcome of all prevocational services is that the beneficiary will pursue individual community employment. These services are time limited to four years, however the goal should be to complete the services. The beneficiary should be within one year of seeking employment. The outcome of this service is an individual career profile and the beneficiary is prepared to move into the next phase of the career path in finding employment.

Place of Service

All CCP services are provided in a variety of locations in the community, integrated alongside individuals without disabilities. During onsite prevocational services, the beneficiary can be at the provider facility.

Staffing Ratios

CCP may occur with one of the following staff ratios:

1. One staff to one beneficiary (1:1); or
2. One staff to two to four beneficiaries (1:2-4).

Onsite prevocational may occur in the following staff ratios:

1. One staff to five to eight beneficiaries (1:5-8).

NOTE: If a beneficiary is already approved to receive 1:1 or 1:2-4 services for prevocational, those beneficiaries may continue to receive that service ratio even when participating in onsite prevocational.

Transportation

1. Transportation is a separate billable service and may be billed on the same day as long as this service is delivered;
2. The transportation rate is billed as a flat rate fee for each day this service is delivered;
3. Provider must provide transportation at least one way in order to be reimbursed;
4. Transportation may be billed if the following circumstances occur:

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First Transportation Starts	First Transportation Ends	Second Transportation Starts	Second Transportation Ends
Beneficiary's home or pickup location	Provider agency building	Provider agency building	Beneficiary's home or pickup location
Beneficiary's home or pickup location	At beginning of first job location or community location (does not go to provider building)	End of last job location or community location	Beneficiary's home or pickup location (does not go to provider building)

5. Use of the EVV system is not mandatory for this service; however, transportation must be entered into the LaSRS to be reimbursed. If EVV is not used, the provider is responsible for preparing and retaining documentation that identifies the person transporting, the person transported, the pick-up time and location, and the drop off time and location for each single transportation service;
6. In order to bill for transportation, the provider agency must provide the service or may subcontract; regardless of who provides the service, they must meet the HHS regulations for transportation. The provider is ultimately responsible;
7. Transportation cannot be provided at the same time another service is being delivered to the same beneficiary, with the exception of CLED (if applicable);
8. Staff providing transportation cannot also be providing another service at the same time (i.e., transportation for one individual at the same time as CLE for another individual); and
9. Transportation is not billable for virtual delivery of onsite prevocational.

Restrictions with Other Services

Beneficiaries receiving onsite prevocational/CCP services may also receive other services on the same day, but not at the same time. The exceptions to this are the following: CLED, MIHC and companion care.

This service is typically for beneficiaries 18 years and older and who are not in school.

The beneficiary's file must contain documentation indicating that this service is not available from programs funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602 (16) or (17) of the IDEA (23 U.S.C. 1401) (16 and 17), as well as any applicable provisions under the State Plan, if applicable.

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Service Limits

1. Standard unit of service is a 15-minute increment;
2. The ROW budget determines the limits;
3. Any time less than 15 minutes of service is not billable or payable and no rounding up of units of service is allowed;
4. Total units are shared and flexed across CCP 1:2-4 and onsite prevocational services 1:5-8; and
5. CCP 1:1 share the total units but the service is listed separate on the POC, as it is not flexed with CCP 1:2-4 or onsite prevocational services 1:5-8.

Provider Qualifications

The supervisory staff who delivers this service must meet one of the following sets of requirements:

1. Possess and maintain a 40-hour SE training certificate of completion from an approved program;
2. Maintain this certificate by completing 15 hours of employment related training and provide documentation to the LGE office by December 31st each year; and
3. Provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

OR

1. Provider is licensed as an ADC provider by LDH with the provider type 13 module;
2. Staff who provides this service receives 15 hours of employment related training annually and provides documentation to the LGE office by December 31st each year; and
3. Provider agency must meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

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Day Habilitation

Day habilitation services are focused on the beneficiary creating their meaningful day through the person-centered planning process. The process should support the beneficiary in how they choose to spend their time and what is most important to each beneficiary.

The integration with individuals without disabilities is expected and should not just include people who are paid to support the beneficiary. Activities should not be created for the sole purpose of serving beneficiaries with developmental disabilities. Beneficiaries should participate in activities and events that are already established in the community.

Day habilitation activities should focus on assisting the beneficiary to gain their desired community living experience, including the acquisition, retention, or improvement in self-help, self-advocacy, socialization and/or adaptive skills, increasing independence, and/or to provide the beneficiary an opportunity to contribute to his or her community. Day habilitation activities may be educational or recreational in nature, which would include activities related to the beneficiary's interests, hobbies, clubs, or sports. Day habilitation services may assist a beneficiary in exploring the community and in making community connections.

Volunteering for nonprofits in the community should be considered, is encouraged and should be provided under the guidelines of the United States Fair Labor Standards Act. Volunteering is a great way for individuals to connect to their community and establish community relationships.

NOTE: Volunteering for the provider agency or provider-owned business is not allowed.

Day habilitation services may be coordinated with needed therapies in the beneficiary's person-centered POC, such as physical therapy. The beneficiary, who is of retirement age, may also be supported to participate in senior community activities or other meaningful retirement activities in the community, such as the local council on aging or senior centers.

Assistance with personal care may be a component part of day habilitation services, as necessary, to meet the needs of a beneficiary, but may not comprise the entirety of the service. Day habilitation is to be furnished in a variety of community settings (i.e., local recreation department, garden clubs, libraries, etc.) other than the beneficiary's residence and is not to be limited to a fixed-site.

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

Under the overarching service title of 'day habilitation', there are two distinct services that may be delivered. Both services may be delivered on the same day in order to support the beneficiary to have the day that they desire. The goal is to support the beneficiary to make choices of how

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they spend their day, both in the community and onsite, in order to help the beneficiary create their meaningful day. Beneficiaries should be involved in making choices and guiding the inclusion of new activities. Discussions should be occurring on a regular basis, but at least quarterly to ensure that the beneficiary is receiving the supports they need and engaging in activities that are important to them.

The two day habilitation services that are available are described in detail below.

Community Life Engagement

CLE refers to services that help support beneficiaries with disabilities to access and participate in purposeful and meaningful activities in their community. The activities may include such things as volunteering, hobbies, shopping, or club participation. The role of CLE varies depending on the particular needs of the beneficiary. This service promotes opportunities and support for community inclusion by building interests and developing skills and potential for meaningful community engagement. It can also help the beneficiary in figuring out areas of interests that could lead to possible competitive integrated employment in the community. Services should be completed in the community in small groups, which allows for a more person-centered planning of activities. Services should result in active, valued participation and engagement in a broad range of integrated activities that build on the beneficiary's interests, preferences, gifts, and strengths, while reflecting their desired outcomes related to community involvement and membership.

This service involves participation in integrated community settings, in activities that include persons without disabilities and with people who are not paid or unpaid caregivers. This service is expected to result in the beneficiary developing and maintaining social roles and relationships, building natural supports, increasing independence, increasing potential for employment, and/or experiencing meaningful community participation and inclusion. Volunteering is expected to be a part of this service as well.

Providers must use an approved activity log to document activities done in the community and frequency. Services may be delivered during the days and times that activities are available and there are no limits to the days or times.

Onsite Day Habilitation

Onsite day habilitation are services that are typically delivered onsite, inside of a day program building. This service should focus on the person-centered planning process, which allows the beneficiary a choice in how they spend their day when onsite and should also consider how to assist the beneficiary to support their time spent in CLE services.

Onsite day habilitation activities should be consistent with the beneficiary's interests, skills, and desires, and should assist the beneficiary to gain their desired meaningful day. Onsite day

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habilitation should be individualized and have choices of activities available that can contribute to a meaningful day for each person. Individual discussions should occur, at least quarterly, to discover new interests and to see how those interests can be incorporated into the day center. Exploring future CLE activities and doing any preparation for those activities is a great way to utilize onsite day habilitation.

Onsite day habilitation can also be offered in a variety of community settings in the ratio of 1:5-8, but should just be in addition to the CLE in a 1:2-4 delivered in the community. The community should be a regular part of onsite day habilitation activities including volunteers and community partnerships and engagement both onsite and in the community. The use of 'reverse integration' does not supplant the inclusion of CLE, but should support a meaningful day.

NOTE: If a beneficiary is already approved to receive 1:1 or 1:2-4 services for day habilitation, those beneficiaries may continue to receive that service ratio even when participating in onsite day habilitation.

Onsite Day Habilitation – Virtual Delivery

Virtual delivery of onsite day habilitation should be used during times that do not allow the beneficiary to attend in person (i.e. medical issues/surgery, an emergency where a provider agency may be closed) or when the beneficiary chooses to not attend in person. Virtual delivery is not the typical delivery method. In order to participate in virtual delivery of the service, the beneficiary should be independent or have natural supports, as this service cannot be billed at the same time as another service. The beneficiary should also have the technology necessary to participate in the virtual service (i.e., internet connection, laptop, smartphone, and/or tablet).

Prior to the beginning of virtual delivery, the following in-person visits are required:

1. Initial assessment of beneficiary and home to determine if it's feasible; and
2. HIPAA compliance training prior to beginning virtual delivery.

Beneficiaries are encouraged to participate in the community through CLE services or onsite day habilitation services in person. The support coordinator and service provider will discuss virtual delivery of day habilitation with each beneficiary and will be included in the POC if chosen by the beneficiary.

Providers will receive written instructions on the delivery of virtual services based on the HIPAA compliance officer's instructions.

When using virtual delivery, providers will follow these guidelines:

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1. Confidentiality still applies for services delivered through virtual delivery. The session must not be recorded without consent from the beneficiary or authorized representative;
2. Develop a back-up plan (e.g., phone number where beneficiary can be reached) to restart the session or to reschedule it, in the event of technical problems;
3. Develop a safety plan that includes at least one emergency contact and the closest ER location, in the event of a crisis;
4. Verify beneficiary's identity, if needed;
5. Providers need the consent of the beneficiary prior to initiating a virtual service with the beneficiary;
6. Beneficiary must be informed of all persons who are present and the role of each person;
7. Beneficiaries may refuse services delivered through virtual delivery; and
8. It is important for the provider and the beneficiary to be in a quiet, private space that is free of distractions during the session.

Providers will ensure that beneficiaries understand the guidelines for participation in a virtual service delivery and HIPAA. Written instructions and guidelines will be provided to each beneficiary.

Beneficiaries and natural supports will be instructed on the following:

1. Finding a space that allows for privacy while participating in the service;
2. Turning the camera off and muting the session if they leave the room while participating in the session, or if someone who is not part of the group comes into the room; and
3. Using the technology required to participate in the virtual delivery of day habilitation, including how to utilize the specific format, signing in and out, etc. The provider will also provide written instructions to the beneficiary.

To ensure that virtual delivery of onsite day habilitation facilitates community integration, the provider agency will continue to incorporate already established community partners into the virtual delivery of onsite day habilitation. For instance, if a meeting that is typically attended in the community with community participation occurring, the beneficiary will join via a face-to-

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face format virtually and therefore still be included in the meeting. Providers will also seek opportunities for beneficiaries to join community online groups in a face-to-face format and seek out such activities as online church services and groups, exercise classes, cooking, and drawing classes. Through virtual delivery of this service, beneficiaries can continue to interact with their friends and community connections during the times when the beneficiary is not participating in person.

If the beneficiary is able to be unsupported during this service, an existing protocol is in place for the person if a health and safety issue arises during this virtual service. The provider agency staff, who is conducting the virtual delivery of this service, will be able to support the beneficiary through any health and safety situation that might arise during the virtual delivery of onsite day habilitation. If the beneficiary is participating in virtual services with the assistance of natural supports, the natural supports will ensure the health and safety of the beneficiary.

All virtual onsite day habilitation services must be on the approved POC and should be delivered as outlined in the OCDD Policy and Procedures manual.

Minimum Requirements for virtual delivery of onsite day habilitation:

1. Must utilize a virtual format that allows for face-to-face interaction;
2. Must utilize EVV to check in and out of virtual onsite day habilitation; and
3. Must utilize an approved activity log to track the days, times and activities that the beneficiary is utilizing virtual delivery of onsite day habilitation.

Housing stabilization service is reimbursed at a prospective flat rate for each approved unit of service provided to the beneficiary.

Place of Service

CLE is delivered in the community and outside of the day habilitation center and the person's residence.

Onsite day habilitation is not limited to a fixed-site building, as it can be furnished in a variety of community settings, other than the person's residence.

Virtual Delivery of Onsite Day Habilitation must be delivered using a format that allows for face-to-face interactions.

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Restrictions with Other Services

Beneficiaries receiving onsite day habilitation/CLE services may also receive other services on the same day, but not at the same time. The exception is that 'CLEd' may be billed at the same time, as the beneficiary is not required to be present for the CLEd service to be delivered.

Onsite day habilitation/CLE services begin when the beneficiary arrives at the site where the activity will take place, which could include the onsite building or if going straight to an activity, when they arrive at the site where the activity will take place.

Staffing Ratios

CLE activities may occur with the following staff ratios:

1. One staff to one beneficiary (1:1);
 - a. CLE 1:1 may be delivered for the following reasons:
 - i. Physical/medical needs that do not allow the beneficiary to participate in a 1:2-4 ratio; or
 - ii. Individual interests that the beneficiary chooses, such as a leisure class, specific interest club, or something that has individual membership.
 - b. CLE services share the overall units, but are not flexed. This service should be listed on the POC.
2. One staff to two to four beneficiaries (1:2-4).

Onsite day habilitation activities may occur with one of the following staff ratios:

1. One staff to one beneficiary (1:1);
2. One staff to two to four beneficiaries (1:2-4); or
3. One staff to five to eight beneficiaries (1:5-8).

NOTE: If a beneficiary is already approved to receive 1:1 or 1:2-4 services for day habilitation, those beneficiaries may continue to receive that service ratio even when participating in onsite day habilitation.

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Service Limits

Day Habilitation Services shall be furnished on a regularly scheduled basis one or more days per week based on the beneficiary’s budget:

1. Standard unit is a 15-minute increment;
2. The ROW budget determines the limits;
3. Any time less than 15 minutes of service is not billable or payable. No rounding up of units is allowed;
4. The total units are shared and flexed across CLE (1:2-4) and onsite day habilitation; and
5. 1:1 CLE share the overall units, but the units are not part of flexing with 1:2-4 or 1:5-8 service; therefore, 1:1 should be listed as a separate service on the POC or alternate schedule.

Transportation

1. Transportation is a separate billable service and may be billed on the same day as long as this service is delivered;
2. The transportation rate is billed as a flat rate fee for each day this service is delivered;
3. Provider must provide transportation at least one way in order to be reimbursed;
4. Transportation may be billed if the following circumstances occur:

First Transportation Starts	First Transportation Ends	Second Transportation Starts	Second Transportation Ends
Beneficiary’s home or pickup location	Provider agency building	Provider agency building	Beneficiary’s home or pickup location
Beneficiary’s home or pickup location	At beginning of first job location or community location (does not go to provider building)	End of last job location or community location	Beneficiary’s home or pickup location (does not go to provider building)

5. Use of the EVV system is not mandatory for this service; however, transportation must be entered into the LaSRS to be reimbursed. If EVV is not used, the provider is responsible for preparing and retaining documentation that identifies

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the person transporting, the person transported, the pick-up time and location, and the drop off time and location for each single transportation service;

6. In order to bill for transportation, the provider agency must provide the service or may subcontract; regardless of who provides the service, they must meet the HHS regulations for transportation. The provider is ultimately responsible;
7. Transportation cannot be provided at the same time another service is being delivered to the same beneficiary, with the exception of CLED (if applicable);
8. Staff providing transportation cannot also be providing another service at the same time as providing transportation (i.e., transportation for one individual at the same time as CLE for another individual); and
9. Transportation is not billable for virtual delivery of onsite day habilitation.

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

Provider Qualifications

Onsite day habilitation/CLE providers must meet the following requirements:

1. Be licensed as an adult day care provider by LDH with a provider type 14; and
2. Meet all requirements in the *Standards for Participation for Medicaid HCBS*, HCBS Settings Rule requirements, and other HCBS guidance as provided.

Community Life Engagement Development

CLED is a service that allows a provider staff, or a 'CLE developer', to connect beneficiaries with organizations and businesses in the community in an effort to align activities with the beneficiaries' interests, foster the development of meaningful relationships and increased membership in their community. The connections should reflect the person's choices, interests and values. The outcome of this service is increased participation and involvement for the beneficiary in community activities as an expressed interest by the beneficiary. This could include civic involvement, volunteering, recreational activities or clubs. The activities should be integrated in the community alongside people without disabilities.

The CLE developer's responsibility is to create tailored activities, memberships, and volunteer opportunities based on each beneficiary's person-centered plan and expressed interests. The individual engaging with community organizations and businesses must possess strong communication skills, be comfortable in discussions, and clearly articulate the mission of the

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service. The person should be well versed in person-first language and can effectively communicate with people.

The goal of CLED is to increase the community connections and membership that reflect the beneficiary's areas of interest and choices.

Place of Service

This service occurs in typical community businesses and organizations, where individuals may be looking for volunteering positions or activities that align with the interests expressed by beneficiaries.

Restrictions with Other Services

This service may be delivered at the same time on the same day as day habilitation, prevocational, and/or SE services, provided that day habilitation is included in the beneficiary's POC.

Documentation Requirements

1. CLED is available only to beneficiaries who also receive day habilitation services on the POC;
2. This service can be billed at the same time the beneficiary is receiving another day or employment service, as the beneficiary does not have to be present in order for this service to be billed; and
3. For every contact made with a beneficiary, the CLED form must be filled out and a copy should be sent to the support coordinator and the LGE office.

Staffing Ratios

CLED may occur with one of the following staff ratios:

1. One staff to one beneficiary (1:1);
2. One staff to two beneficiaries (1:2); or
3. One staff to three beneficiaries (1:3).

The use of the electronic visit verification (EVV) system is mandatory for all services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS).

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Transportation

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

Service Limits

1. Standard unit of services is a 15-minute increment;
2. 240 units are allowed per POC year (60 hours);
3. Total units are shared amongst the three different ratios; and
4. The use of the EVV system is mandatory for all services. The EVV system requires the electronic check in/out in the LaSRS.

Provider Qualifications

The provider agency delivering this service must meet the following requirements:

1. Be licensed as an adult day care provider by the LDH with the provider type 14 module; and
2. Meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements and HCBS guidance as provided.

Housing Stabilization Transition Service and Housing Stabilization Service

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

Housing Stabilization Transition Service

Housing stabilization transition services enable beneficiaries who are transitioning into a PSH unit, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. Conducting a housing assessment that identifies the beneficiary's preferences; related to housing (type and location of housing, living alone or living with someone else, accommodations needed, and other important preferences) and identifying the beneficiary's needs for support to maintain housing, including:

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- a. Access to housing;
 - b. Meeting the terms of a lease;
 - c. Eviction prevention;
 - d. Budgeting for housing/living expenses;
 - e. Obtaining/accessing sources of income necessary for rent;
 - f. Home management;
 - g. Establishing credit; and
 - h. Understanding and meeting the obligations of tenancy as defined in the lease terms.
2. Assisting the beneficiary to view and secure housing as needed. This may include:
- a. Arranging or providing transportation;
 - b. Assisting in securing supporting documents/records;
 - c. Assisting in completing/submitting applications;
 - d. Assisting in securing deposits; and
 - e. Assisting in locating furnishings.
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 beneficiary’s approach to meeting the goal(s); and
 - c. Identifies where other provider(s) or services may be required to meet the goal(s).
4. Participating in the development of the POC and incorporating elements of the housing support plan; and

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

Standards

Housing stabilization transition services must be provided by PSH agencies that are enrolled in Medicaid to provide this service, comply with LDH rules and regulations, and are listed as a provider of choice on the FOC form.

Service Exclusions

No more than 165 units of combined housing stabilization transition services and housing stabilization services (see definition) may be used per POC year without written approval from the OCDD state office.

Service Limits

This service is only available upon referral from the support coordinator and is not duplicative of other waiver services, including SC. This service is only available to persons who are residing in, or who are linked for the selection process of a Louisiana PSH unit.

No more than 72 units of housing stabilization services may be used per POC year without approval from the OCDD state office. A standard unit of service is equal to 15 minutes (1/4 hour).

Reimbursement

Payment will not be authorized until the LGE gives final POC approval.

The LGE office reviews and ensures that all requirements are met. If all requirements are met, the POC is approved and the payment is authorized. The PSH provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary (FI) for services provided.

Housing stabilization transition services will be reimbursed at a prospective flat rate for each approved unit of service provided to the beneficiary.

Housing Stabilization Service

Housing stabilization services enable waiver beneficiaries to maintain their own housing as set forth in the beneficiary’s approved POC. Services must be provided in the home or a community setting. This service includes the following components:

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1. Conducting a housing assessment that identifies the beneficiary's preferences related to housing (type and location of housing, living alone or living with someone else, accommodations needed, and other important preferences), and identifying the beneficiary's needs for support to maintain housing, including:
 - a. Access to housing;
 - b. Meeting the terms of a lease;
 - c. Eviction prevention;
 - d. Budgeting for housing/living expenses;
 - e. Obtaining/accessing sources of income necessary for rent;
 - f. Home management;
 - g. Establishing credit; and
 - h. Understanding and meeting the obligations of tenancy as defined in the lease terms.
2. Participating in the development of the POC, incorporating elements of the housing stabilization service provider plan, and in POC renewal and updates, as needed;
3. Developing an individualized housing stabilization service provider plan based upon the housing assessment that:
 - a. Includes short and long-term measurable goals for each issue;
 - b. Establishing the beneficiary's approach to meeting the goal(s); and
 - c. Identifying where other provider(s) or services may be required to meet the goal(s).
4. Providing supports and interventions according to the individualized housing stabilization service provider plan. If additional supports or services are identified as needed outside of the scope of housing stabilization services, the needs must be communicated to the support coordinator;

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5. Providing ongoing communication with the landlord or property manager regarding:
 - a. The beneficiary's disability;
 - b. Accommodations needed; and
 - c. Components of emergency procedures involving the landlord or property manager.
6. Updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status; and
7. Providing supports to retain housing or locate and secure housing if at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income), housing stabilization services will provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

Standards

Housing stabilization transition services must be provided by PSH agencies that are enrolled in Medicaid to provide this service, comply with LDH rules and regulations, and are listed as a provider of choice on the FOC form.

Service Exclusions

No more than 165 units of combined housing stabilization transition services and housing stabilization services (see definition) may be used per POC year without written approval from the OCDD state office.

Service Limits

This service is only available upon referral from the support coordinator. This service is not duplicative of the other waiver services including SC. This service is only available to persons who are residing in a Louisiana PSH unit.

No more than 93 units of housing stabilization services can be used per year without written approval from the support coordinator. A standard unit of service is equal to 15 minutes (1/4 hour).**Reimbursement**

Payment will not be authorized until the final POC approval is received.

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The LGE office reviews all documents to ensure all requirements are met. If all requirements are met, the POC is approved and the payment is authorized. The PSH provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary (FI) for services provided.

Housing stabilization service is reimbursed at a prospective flat rate for each approved unit of service provided to the beneficiary.

Adult Day Health Care Services

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

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

1. Medical care management;
2. Transportation between the beneficiary's place of residence and the ADHC (if the beneficiary is accompanied by the ADHC staff) in accordance with licensing standards;
3. Assistance with ADL;
4. Health and nutrition counseling;
5. An individualized exercise program;
6. An individualized goal-directed recreation program;
7. Health education classes;
8. Individualized health/nursing services; and
9. Meals. Meals shall not constitute a full nutritional regimen (3 meals per day), but shall include a minimum of 2 snacks and a hot, nutritious lunch per day.

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

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Nurses shall be involved in the beneficiary's service delivery as specified in the POC or as needed. Each beneficiary has a POC from which the ADHC shall develop an individualized service plan based on the beneficiary's POC. If the individualized service plan calls for certain health and nursing services, the nurse on staff shall ensure that the services are delivered while the beneficiary is at the ADHC facility.

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

1. Monitoring vital signs appropriate to the diagnosis and medication regimen of each beneficiary no less frequently than monthly;
2. Administering medications and treatments in accordance with physicians' orders;
3. Developing and monitoring beneficiaries' medication administration plans (self-administration and staff administered) of medications while the beneficiary is at the ADHC center; and
4. Serving as a liaison between the beneficiary and medical resources including the treating physician.

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

Transportation

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

1. The cost of transportation is included in the rate paid to ADHC centers;
2. The beneficiary and their family may choose to transport the beneficiary to the ADHC center. Transportation provided by the beneficiary's family is not a reimbursable service; and
3. Transportation to and from medical and social activities when the beneficiary is accompanied by ADHC center staff.

Service Units and Limitations

The following service limitations apply:

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1. Services must be billed in 15 minute units;
2. ADHC services shall be provided no more than 10 hours per day and no more than 50 hours per week (exclusive of transportation time to and from the ADHC center, as specified in the beneficiary’s POC); and
3. These services must be provided in the ADHC center that has been chosen by the beneficiary.

Service Exclusions

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

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

Monitored In-Home Caregiving Services

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

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

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

MIHC providers must employ professional staff, including a RN and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The provider agency must:

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

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3. Capture daily notes electronically and use the information collected to monitor beneficiary health and caregiver performance; and
4. Make such notes available to support coordinators and the state, upon request.

The principal caregiver is responsible for supporting the beneficiary to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. Supervision or assistance in performing ADL;
2. Supervision or assistance in performing instrumental ADL;
3. Protective supervision provided solely to assure the health and welfare of a beneficiary;
4. Supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration;
5. Supervision or assistance while escorting / accompanying the individual outside of the home to perform tasks, including instrumental ADL, health maintenance or other needs as identified in the POC, and to provide the same supervision or assistance as would be rendered in the home; and
6. Extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or RN.

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

Service Limitations

LDH will reimburse for MIHC based on a 2 tiered model which is designed to address the beneficiary's acuity. The following service limitations apply:

1. MIHC providers shall not bill and/or receive payment on days that the beneficiary is attending or admitted to a program or setting (e.g., hospitals, nursing facilities, etc.) which provides ADL or IADL assistance;

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2. The provision of MIHC services outside of the borders of the state (e.g., overnight excursions, vacation, etc.) is prohibited without written approval by OCDD or its designee;
3. Individual receiving Hospice services may receive MIHC services in the ROW as long as services are not related to terminal illness or services are not duplicative of Hospice POC;
4. Professional staff (care manager) employed by the HCBS provider shall determine if a beneficiary is receiving Hospice services and must ensure that services in the waiver POC are not duplicative of services in Hospice POC. If duplication of services is imminent, the individual may not elect MIHC services;
5. If hospice services terminal diagnosis is related to developmental disability diagnosis the individual may elect to terminate or remain in hospices services as this is a duplication of Medicaid services;
6. If Professional staff determine there is not duplication of services, then the care coordinator may proceed with the (MIHC) POC coordinated with the hospice provider; and
7. OCDD Waiver support coordinator must coordinate all services with Hospice provider and MIHC care manager.

Services Exclusions

Beneficiaries electing MIHC are not eligible to receive the following ROW services during the period of time that the beneficiaries are receiving MIHC services:

1. CLS;
2. Companion Care supports;
3. Host Home;
4. Shared Living supports;
5. ADHC; or
6. Skilled Nursing.

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Expanded Dental Services for Adult Waiver Beneficiaries

Please refer to the Dental Benefit Program Manager Manual:

<https://ldh.la.gov/assets/medicaid/DBPMP/DBPMMManual-Masterversion5.1.24.pdf>

Financial Management Services

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

The FEA is the fiscal agent that assures financial accountability for self-direction services.

Refer to Chapter 3 - Fiscal/Employer Agent (F/EA) for additional information at:

https://www.lamedicaid.com/provweb1/providermanuals/FEA_main.htm

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SECTION 38.2: SELF-DIRECTION OPTION**PAGE(S) 2**

SELF-DIRECTION OPTION

Self-direction is a voluntary service delivery option in the Residential Options Waiver (ROW) that allows the beneficiary (or their authorized representative) to become the employer of the direct service workers (DSWs) they choose to hire to provide their supports. As the employer, the beneficiary or the beneficiary's authorized representative is responsible for recruiting, training, supervising, and managing the DSWs.

A required component of the self-direction option is the use of a fiscal/employer agent (F/EA) to perform the beneficiary's employer-related financial management services (FMS). Beneficiaries must utilize support coordination services for the development of the plan of care (POC), budget planning, ongoing evaluation of supports and services, and for organizing the unique resources the beneficiary's needs.

Refer to the [F/EA Manual](#) for additional information.

The beneficiary may choose to self-direct all or part of their community living supports.

Beneficiaries can choose to receive other services for which the beneficiary is eligible from a provider agency.

Beneficiaries in the self-direction option must:

1. Be a ROW beneficiary utilizing Community Living Supports;
2. Be able to participate in this option without a lapse or decline in quality of care or an increased risk to their health and welfare;
3. Complete the mandatory training including rights and responsibilities of managing their own services and supports offered by the support coordinator;
4. Understand the right, risks, and responsibilities of managing their own care, effectively managing their POC using an individual budget; or if unable to make decisions independently, have a willing decision maker (authorized representative who is listed on the beneficiaries' POC) who understands the rights, risks, and responsibilities of managing the care and supports of the beneficiary within their individualized budget;
5. Authorized representatives, legally responsible individuals, and legal guardians may be the employer of the self-directed option but may not also be the employee;
6. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide self-directed community living supports services for a beneficiary

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SECTION 38.2: SELF-DIRECTION OPTION**PAGE(S) 2**

provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary;

7. Family members who are employed in the self-directed option must meet the same standards as direct support staff that are not related to the beneficiary; and
8. Family members who live in the home with the beneficiary cannot exceed a total of 40 hours per week when employed in the self-directed option.

Follow all rules and requirements pertaining to self-direction as outlined in the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD) Self-Direction Option Employer Handbook.

Termination of the Self-Direction Option

Termination from this option may be either voluntary or involuntary and the support coordinator will assist with the transition:

1. A revision of the plan of care by the support coordinator is required in order to eliminate the F/EA and add the beneficiary's chosen Medicaid-enrolled Direct Service Provider(s) (DSPs);
2. Beneficiaries who return to traditional DSP must remain with this DSP for at least 90 calendar days (3 months) before opting to return to the self-direction option if they are eligible to do so;
3. Beneficiaries may choose at any time to voluntarily return to a traditional DSP; and
4. A beneficiary may be removed from Self-Direction and required to return to traditional DSP if there are any violations of the ROW or Self-Direction program rules.

Financial Management Services

FMS are provided by a Medicaid enrolled F/EA. The F/EA is the fiscal agent that assures financial accountability for self-direction services.

Refer to the F/EA Manual for additional information at:

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

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SECTION 38.3: BENEFICIARY REQUIREMENTS**PAGE(S) 6**

BENEFICIARY REQUIREMENTS

To qualify for the Residential Options Waiver (ROW), an individual must meet all of the following eligibility criteria:

1. Have an intellectual and/or developmental disability and meets the medical requirements as defined in the Developmental Disability Law. (See Appendix A);
2. Be determined eligible through the developmental disabilities entry process;
3. Their name is Request for Services Registry (RFSR);
4. Meet the financial Medicaid eligibility criteria for Medicaid services;
5. Meet the requirement for an intermediate care facility for individuals with an intellectual disability (ICF/IID) level of care (LOC), which requires active treatment of a developmental disability under the supervision of a qualified intellectual disability professional;
6. Have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the Office for Citizens with Developmental Disabilities (OCDD) waiver that will meet the needs of the individual;
7. Must be a resident of Louisiana;
8. Must be a citizen of the United States or a qualified alien; and
9. Have assurance that health and welfare of the individual can be maintained in the community with the provision of the ROW services.

Criteria for one of the following target groups:

1. Meets ICF/IID LOC and is being served in the OCDD Host Home contracts;
2. Meets ICF/IID LOC and needs home and community-based services (HCBS) due to a health and/or safety crisis situation (crisis diversion);
3. Is an adult in a nursing facility who is appropriate for transition to HCBS residential services;

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SECTION 38.3: BENEFICIARY REQUIREMENTS**PAGE(S) 6**

4. Meets the LOC to qualify for ROW eligibility and is on the RFSR;
5. Is a child (birth through age 18 years) in a nursing facility requiring high-need rates who is appropriate for transition to HCBS residential services and who meets the LOC to qualify for ROW eligibility. Members of this group must participate in the Money Follows the Person (MFP) Rebalancing Demonstration;
6. Is a resident in an ICF/IID who wishes to transition to HCBS residential services through a voluntary conversion opportunity. Members of this group have the choice of participating in the MFP Rebalancing Demonstration;
7. Is a resident in an ICF/IID who is on the RFSR who wishes to transition to HCBS residential services and is eligible for the ROW;
8. Is a resident in a Supports and Services Center who wishes to transition to HCBS residential services; or
9. Transition of eligible Individuals with Intellectual and Developmental Disability services in either the Office of Adults and Aging Services (OAAS) Community Choices Wavier (CCW) or OAAS Adult Day Health Care Waiver (ADHC) to the ROW.

Persons residing in an ICF/IID who wish to transition to HCBS residential services, and who are eligible for the ROW, have a choice of participating in the MFP Rebalancing Demonstration. All persons who participate must meet criteria for participation as established by OCDD protocol and must meet demonstration operational parameters (e.g. available funding) established by the demonstration award.

As part of OCDD's Tiered Waiver approach, all children under age 21 enter the waiver system into the Children's Choice (CC) Waiver and all adults enter into the Supports Waiver (SW). A person-centered planning process, which includes completion of a needs-based assessment, is utilized during the initial phase to develop the individual's life vision/goals and develop support strategies and identify services/supports needed. If an individual's needs cannot be met with the initial waiver they may request moving up to the next waiver in the Tiers. The ROW is the second tier within the OCDD Tiered Waiver process.

To remain eligible for waiver services, a beneficiary must receive residential services and support coordination at least once every 30 days.

NOTE: There is no age restriction for individuals to access the ROW.

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SECTION 38.3: BENEFICIARY REQUIREMENTS

Developmental Disability Request for Services Registry

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots. Requests for developmental disabilities services are made through the entry unit of the applicant’s local governing entity (LGE) for the geographic area in which they reside. Only requests from the individual or their authorized representative will be accepted.

Once it has been determined by the entry unit of the LGE that the individual meets the definition of having a developmental disability as defined by the Louisiana Developmental Disability Law (see Appendix A) as eligible for Developmental Disabilities services and the individual is seeking Waiver services, the LGE staff will request addition of the individual’s name to the RFSR.

Once an individual is added to the RFSR, they will be assigned to a screener who will conduct the required screening.

Waiver opportunities are offered based on an individual’s urgency of need which is determined by screening with the use of an appropriate screening tool as prescribed by OCDD (currently the Screening for Urgency of Need (SUN) tool). Available Waiver opportunities are sent to individuals based on their SUN score.

If there are not enough Waiver opportunities for those who have met SUN score requirements, the available Waiver opportunities will be offered to individuals based on both their SUN Score and their RFSR protected date/time beginning with those who have the highest SUN scores and the earliest protected date. Individuals or their family may verify the date of request on the RFSR by calling the applicant’s LGE.

OCDD currently uses a tiered waiver system for accessing developmental disabilities HCBS Waiver services. This system was designed to ensure that the needs of individuals who qualify for Waiver services are sufficiently met by linking them to the most appropriate waiver program based on person-centered planning and a needs-based assessment. Initial offers are made for participation in the most appropriate Waiver program. If an individual accepts an offer for a Waiver program other than the ROW and finds that they are in need of the ROW, the individual must contact the Support Coordinator to make a request for participation in the ROW.

NOTE: Acceptance of any waiver offer means automatic closure on the RFSR. Once an individual accepts an offer for Waiver Services, they will be linked to the Waiver program chosen and the request will be closed on the RFSR.

Verifying Screening for Urgency of Need (SUN) and Request Date

Applicants or their authorized representatives may verify their SUN score and request date by calling their local LGE. (See Appendix C).

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SECTION 38.3: BENEFICIARY REQUIREMENTS**PAGE(S) 6**

Level of Care

The ROW is an alternative to institutional care. All waiver applicants must meet the definition of developmental disability as defined in the Developmental Disability Law. (See Appendix A). The LGE will issue either a Statement of Approval (SOA) or a Statement of Denial (SOD).

The OCDD “Request for Medical Eligibility Determination,” 90-L Form is the instrument used to determine if an applicant meets the LOC of an ICF/IID. The 90-L Form must be:

1. Submitted with the individual’s initial and annual plan of care (POC);
2. Completed 180 days or less before the date on which the ROW service is approved to begin, and annually thereafter;
3. Completed, signed, and dated by the applicant’s Louisiana licensed primary care physician (PCP). A licensed advanced nurse practitioner (NP) or licensed physician’s assistant may sign the 90-L, but the supervising or collaborating physician’s name and address must be listed;
4. Submitted with the initial or annual POC to the LGE office. The LGE office is responsible for determining that the required LOC is met for each beneficiary; and
5. The applicant or their authorized representative is responsible for obtaining the completed 90-L Form from the applicant’s PCP within the following timeframes:
 - a. Prior to certification for the waiver for an initial POC; and
 - b. No more than 180 days before the annual POC start date.

The support coordinator is responsible for collecting the material necessary to make this determination and convening the person-centered planning team to formulate the POC, which documents all services to be arranged, including both natural supports and those reimbursed under ROW.

Documentation of LOC and the POC is submitted to the LGE for a decision to determine if the applicant meets the criteria and LOC requirements for admission to an ICF/IID. The LGE staff assesses the overall support needs of the applicant, including health and welfare, and determines if they will be met by the services and supports designed.

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SECTION 38.3: BENEFICIARY REQUIREMENTS**PAGE(S) 6**

Denial or Discharge Criteria

Beneficiary's will be denied admission to, or discharged from, the waiver if one of the following occurs:

1. The individual does not meet the criteria for Medicaid financial eligibility;
2. Loss of Medicaid financial eligibility, as determined by the Bureau of Health Services Financing (BHSF);
3. The individual does not meet requirements or loses eligibility for ICF/IID LOC, as determined by the LGE;
4. The individual does not meet or loses developmental disability system eligibility;
5. The beneficiary is incarcerated or placed under the jurisdiction of penal authorities, courts, or state juvenile authorities;
6. The beneficiary resides in another state, or has a change of residence to another state, with the intent to become a resident of that state;
7. The beneficiary is admitted to an ICF/IID or nursing facility with the intent to stay and not return to waiver services;

NOTE: The waiver beneficiary 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 beneficiary will be discharged from the waiver on the 91st day if the beneficiary is still in the facility. Payment for waiver services will not be authorized when the beneficiary is in a facility.

8. The health and welfare of the beneficiary in the community cannot be assured through the provision of waiver services, as determined by the LGE, or OCDD Central Office, i.e., the beneficiary presents a danger to themselves or others;
9. Failure to cooperate in either the eligibility determination process, the development of the POC, or the initial or annual implementation of the POC, or to fulfill their responsibilities as a ROW beneficiary; or
10. Continuity of stay/services is interrupted as a result of the beneficiary not receiving and/or refusing waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

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NOTE: Continuity of stay/services will not apply to interruptions due to admission to a hospital, an ICF/IID facility, or to a nursing facility. This interruption cannot exceed 90 days. During this 90-day period, OCDD will not authorize payment for ROW services. The beneficiary must be discharged from the ROW if the treating physician documents that the institutional stay will exceed 90 days.

In the event of Force Majeure, support coordination agencies, direct service providers (DSPs), and beneficiaries whenever possible, will be informed in writing, by phone, and/or via the Louisiana State Medicaid website of interim guidelines and timelines for retention of waiver slots and/or temporary suspension of continuity of services.

The DSP is required to notify the support coordination agency within 24 hours if the provider has knowledge that the beneficiary has met any of the above stated discharge criteria.

RIGHTS AND RESPONSIBILITIES

Beneficiaries of Residential Options Waiver (ROW) services are entitled to the specific rights and responsibilities that accompany eligibility and participation in the Medicare and Medicaid waiver programs and those contained in the Louisiana Developmental Disability Law of 2005 (La. R.S. 28:452.1).

Support coordinators and service providers must assist beneficiaries to exercise their rights and responsibilities. Every effort must be made to assure that applicants or beneficiaries understand their available choices and the consequences of those choices. Support coordinators and service providers are bound by their provider agreement with Medicaid to adhere to the following policies regarding beneficiary rights.

Freedom of Choice of Program

Applicants and/beneficiaries who qualify for an intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care (LOC) have the freedom to select institutional or community-based services. Applicants and beneficiaries have the responsibility to participate in the evaluation process. This includes providing the medical and other pertinent information or assisting in obtaining it for use in the person-centered planning process and certification for services.

Notification of Changes

Support coordinators and service providers may not approve or deny eligibility for the waiver or approve services in the waiver program.

The Louisiana Department of Health (LDH) - Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for the ROW program. In order to maintain eligibility, beneficiaries have the responsibility to inform BHSF of changes in their income, address, and living situation.

The LDH - Office for Citizens with Developmental Disabilities (OCDD) is responsible for approving LOC and medical certification per the plan of care (POC). In order to maintain this certification, beneficiaries have the responsibility to inform OCDD through their support coordinator of any significant changes, which will affect their service needs.

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SECTION 38.4: RIGHTS AND RESPONSIBILITIES**PAGE(S) 4****Participation in Care**

Support coordinators and service providers shall encourage and empower beneficiaries and authorized representatives to participate in all person-centered planning meetings and any other meeting concerning their services and supports. Person-centered planning is utilized in developing all services and supports to address the beneficiary's unmet needs. Beneficiaries and authorized representatives have the responsibility to guide the discussion with assistance from the support coordinator and service providers. By taking an active part in planning their services, the beneficiary is better able to utilize the available supports and services.

In order for providers to offer the level of service necessary to ensure the beneficiary's health, welfare, and support, the beneficiary must report any change in their service needs to the support coordinator and service provider(s).

At the request of the beneficiary or authorized representative, the support coordinator must request changes in the amount of services at least 7 days before taking effect, except in emergencies. Service providers may not initiate requests for change of service or modify the POC without the participation and consent of the beneficiary.

Freedom of Choice of Support Coordination and Service Providers

Support coordinators should be aware at the time of admission to the waiver and every 6 months thereafter that beneficiaries have the opportunity to change support coordination providers, if one is available. Beneficiaries may request a change by contacting the local governing entity (LGE).

Support coordinators provide beneficiaries with their choice of direct service providers (DSPs) and help arrange for the services included in the POC. Beneficiaries have the opportunity to choose service providers initially and once every service authorization quarter (3 months), unless a change is requested for good cause.

Voluntary Participation

Providers must assure that the beneficiary's health and welfare needs are met. As part of the planning process, methods to comply with these assurances may be negotiated to suit the beneficiary's needs and outcomes. Beneficiaries have the right to refuse services, to be informed of the alternative services available to them, and to know the consequences of their decisions. Therefore, a beneficiary will not be required to receive services that they may be eligible for, but does not wish to receive. The intent of the ROW program is to provide community-based services to individuals who would otherwise require institutionalization.

CHAPTER 38: RESIDENTIAL OPTIONS WAIVER**SECTION 38.4: RIGHTS AND RESPONSIBILITIES****PAGE(S) 4****Compliance with Civil Rights**

Providers shall operate in accordance with Titles VI and VII of the Civil Rights Act of 1964, as amended, and the Vietnam Veterans Readjustment Act of 1974 and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services (DHHS). This means that all services and facilities shall be available to persons without regard to race, color, religion, age, sex, or national origin. Beneficiaries have the responsibility to cooperate with providers by not requesting services that in any way violate state or federal laws.

Quality of Care

Providers must be competent, trained, and qualified to provide services to beneficiaries as outlined in the POC. In cases where services are not delivered according to the POC, or there is abuse or neglect on the part of the provider, the beneficiary shall follow the complaint reporting procedure and cooperate in the investigation and resolution of the complaint. Beneficiaries may not request providers to perform tasks that are illegal or inappropriate and may not violate the rights of providers.

Additional Rights

Beneficiaries have the right to control their personal resources, engage in community life, and receive services in the community to the same degree of access as individuals not receiving home and community based services (HCBS). Individuals have choice regarding services and supports, and who provides them. Additional rights include the following:

1. Freedom and support to control their own schedules and activities;
2. Access to food at any time, unless contraindicated due to health or safety and so documented in the POC;
3. Freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
4. Visitors of their choosing at any time;
5. Setting must be physically accessible to the individual; and
6. Control of personal resources, including wages earned in prevocational services or supported employment services.

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SECTION 38.4: RIGHTS AND RESPONSIBILITIES

Grievances/Fair Hearings

Each support coordination or DSP shall have grievance procedures through which beneficiaries may file a complaint concerning the supports or services that they receive. The support coordinator shall advise beneficiaries of this right and of their rights to appeal any denial or exclusion from the program or failure to recognize a beneficiary’s choice of a service and of their right to a fair hearing through the Medicaid program. In the event of a fair hearing, a representative of the service provider or support coordination agency shall appear and participate in the proceedings.

The beneficiary has a responsibility to bring problems to the attention of providers or the Medicaid program and to participate in the grievance or appeal process.

Rights and Responsibilities Form

A copy of the form with a complete list of the beneficiary’s rights and responsibilities can be found on the website. (Refer to Appendix D). The support coordinator must review these rights and responsibilities with the beneficiary and their authorized representative as part of the initial intake process into waiver services.

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SECTION 38.5: SERVICE ACCESS AND AUTHORIZATION PAGE(S) 10

SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for an additional Office of Citizens with Developmental Disabilities (OCDD) waiver opportunity, or an existing opportunity is vacated and funded, the next individual on the Developmental Disability Request for Services Registry (DDRFSR) with the highest urgency of need screen score will receive a written notice indicating that a waiver opportunity is available. That individual will receive a needs based assessment and participate in a person centered planning process. Utilizing the Tiered Waiver process, if it is determined that the Residential Option Waiver (ROW) is the most appropriate waiver for this individual a ROW offer will be extended.

The applicant will receive a waiver offer packet that includes a Support Coordination Agency Freedom of Choice (FOC) form. The support coordinator is a resource to assist individuals in the coordination of needed supports and services. The applicant must complete and return the packet to be linked to a support coordination agency.

Prior to linkage to a support coordination agency, the applicant must have provided the Medicaid data contractor with a current 90-L form that has been completed, signed and dated by their Louisiana licensed primary care physician (PCP). Once linked, the support coordinator will assist the applicant in gathering the documents which may be needed for both the financial eligibility and medical certification process for level of care (LOC) determination. The support coordinator informs the individual of the FOC of enrolled waiver providers, the availability of services as well as the assistance provided through the support coordination service.

Once it has been determined that the applicant meets the LOC requirements for the program, a second home visit is made to finalize the plan of care (POC). The following must be addressed in the POC:

1. The applicant’s assessed needs;
2. The type and quantity of services (including waiver and all other services) necessary to maintain the applicant safely in the community;
3. The individual cost of each service (including waiver and all other services); and
4. The total cost of services covered by the POC.

Provider Selection

The support coordinator must present the beneficiary with a list of providers who are enrolled in Medicaid to provide those services that have been identified on the POC. The support coordinator will have the beneficiary or responsible representative complete the provider FOC form initially

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SECTION 38.5: SERVICE ACCESS AND AUTHORIZATION PAGE(S) 10

and annually thereafter for each identified waiver service.

Initial Plan of Care (POC)

The support coordinator will take the following actions:

1. Notify the provider that the beneficiary has selected their agency to provide the necessary service;
2. Schedule a meeting with the provider and the beneficiary to discuss services needed by the beneficiary;
3. After the meeting forward a copy of the draft POC to the provider and request sign and return the:
 - a. Budget pages; and
 - b. Required POC provider attachments (e.g. Attachments B through I) as indicated in the POC.
4. Forwarding the initial POC packet including provider attachments to the local governing entity (LGE) for review and approval.

Annual Plan of Care

Annual POCs follow the same process as an initial POC except for the following:

1. Support coordinator supervisors are allowed to approve an annual POC based on OCDD policy; and
2. A copy of any POC approved by the support coordinator supervisor will be forwarded to the LGE.

NOTE: ROW services cannot begin prior to the LGE or support coordinator supervisor’s approval of the POC.

Prior Authorization

All services in the ROW program must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid beneficiary by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and that it meets criteria for reimbursement. PA does not guarantee payment

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SECTION 38.5: SERVICE ACCESS AND AUTHORIZATION PAGE(S) 10

for the service as payment is contingent upon the passing of all edits contained within the claims payment process, compliance with all policy and rules for the covered services, the beneficiary's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

PA is performed by the Medicaid data contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service. PAs are issued in quarterly intervals directly to the provider, with the last quarterly authorization ending on the POC end date.

PA revolves around the POC document, which means that only the service codes and units specified in the approved POC will be prior authorized. Services provided without a current PA are not eligible for reimbursement.

The service provider is responsible for the following activities:

1. Checking PAs to verify that all PAs for services match the approved services in the beneficiary's POC. Any mistakes must be immediately corrected to match the approved services in the POC;
2. Verifying that the direct service worker's (DSW's) timesheet or electronic clock in/out is completed correctly and that services were delivered according to the beneficiary's approved POC prior to billing for the service;
3. Verifying that services were documented and provided as evidenced by timesheets or electronic clock in/out and progress notes and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;

Verifying service data in the direct service provider (DSP), electronic visit verification (EVV) system or Louisiana Service Reporting System (LaSRS) depending on the service and modifying the data, if needed, based on actual service delivery;
4. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;
5. It is the provider's responsibility to ensure that billing information for the dates of service, procedure codes, and number of units delivered is correct and matches the information in LaSRS. Inconsistencies between LaSRS and the provider's billing system may result in recoupment;
6. Billing only for the services that were delivered to the beneficiary and are approved in the beneficiary's POC;

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7. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary (FI) with each payment; and
8. Checking billing records to ensure that the appropriate payment was received.

NOTE: Service providers have a one-year timely filing billing requirement under Medicaid regulations.

In the event that reimbursement is received without an approved PA, the amount paid is subject to recoupment.

NOTE: Authorization for services will not be issued retroactively unless **approved due to** special circumstances **by the OCDD Waiver Director/designee.**

Post Authorization

To receive post authorization, a service provider must ensure that service delivery is reported accurately in the post authorization system maintained by the Medicaid data contractor. The Medicaid data contractor checks the service delivery information located in the post authorization system against the prior authorized unit of service. Once post authorization is granted, and billing is correctly submitted by the service provider, reimbursement for the appropriate units of service will occur.

Providers of ROW services must ensure that the service provided, quantity of services, and dates of service billed align with actual delivery of services. Span date billing for services is acceptable as long as the dates align with the services being billed. Services billed and paid in excess of the services provided **on a specific date** will be recouped.

Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

One - Time Transitional Expenses

The support coordinator must develop a plan to include the transition expenses for individuals who are moving from an intermediate care facility for individuals with intellectual developmental disabilities (ICF/IID) or other institution into their own residence in the community. No funds will be disbursed without PA of expenditures. The following procedure must be followed to access these funds:

1. The support coordinator must complete the “Transitional Expenses Planning and Approval (TEPA) Request Form,” with input from the beneficiary and their circle of support, to document the need for transitional expenses, identify the designated

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purchaser, and estimate the cost of the items or services that are needed. The beneficiary may choose to be the designated purchaser or may select their authorized representative, support coordinator, or provider to act as the designated purchaser. (See Appendix D for a copy of this form);

2. The support coordinator must request pre-approval from the LGE by submitting the TEPA request form and the POC packet, including the POC budget sheet identifying the estimated TEPA cost, procedure code, provider and provider number, at least 10 working days prior to the beneficiary's actual move date;
3. The LGE sends the completed pre-142 approval letter and pre-approved TEPA request form to the support coordinator and OCDD Central Office Fiscal Section. A copy of the pre-142 approval letter will also be sent to the Medicaid parish office. The purchasing process cannot begin until the pre-142 approval letter is issued to the support coordinator;
4. The support coordinator assists the designated purchaser with obtaining the items on the pre-approved TEPA request form. The beneficiary must be provided choice in the items being purchased on their behalf;
5. After purchases are made, the support coordinator is responsible for:
 - a. Obtaining the original receipts from the designated purchaser;
 - b. Identifying the pre-approved items to be reimbursed;
 - c. Notating the actual cost of the pre-approved items on the TEPA request form;
 - d. Summarizing all items purchased by the designated purchaser on the "TEPA Invoice" form;
 - e. Completing the "Request for Taxpayer Identification Number and Certification" (W-9 form) if the designated purchaser is not established as a state vendor; and
 - f. Informing the designated purchaser of the timeframes and procedures to be followed in order to obtain reimbursement.
6. The support coordinator must submit the pre-approved TEPA request form, original receipts, W-9 form (if applicable), and the TEPA Invoice form to the LGE within 90 calendar days following the precertification home visit; The LGE reviews the

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- purchased items with the beneficiary/authorized representative at the pre-certification home visit for approval;
7. The LGE mails the 18-W form, original receipts, pre-approved TEPA request form, and TEPA Invoice form to the OCDD Central Office Fiscal Section upon receipt. Payment will not be authorized until the LGE gives final POC approval upon receipt of the 18-W form;
 8. The OCDD Central Office Fiscal Section establishes a transition expense record for the beneficiary and utilizes the pre-approved TEPA request form to ensure that only the item/services listed are reimbursed to the designated purchaser;
 9. The support coordinator must submit to the LGE a revised POC budget sheet if there are any cost differences between the approved estimated TEPA cost and the actual TEPA cost;
 10. The OCDD Central Office Fiscal Section sends the “OCDD Verification of Actual TEPA Costs” form to the LGE for service authorization;
 11. The LGE gives final approval on the “OCDD Verification of Actual TEPA Costs” form and faxes it to the Medicaid data contractor along with the approved TEPA request form and accompanying POC budget sheets. A copy of the “OCDD Verification of Actual TEPA Costs” form is faxed back to the OCDD Central Office Fiscal Section for documentation in the OCDD payment record;
 12. Service authorization is issued to the OCDD Central Office Fiscal Section for the actual cost of items as identified on the approved TEPA request form. Any new items not on the original approved TEPA Request Form will not be reimbursed;
 13. The OCDD Central Office forwards the reimbursements to the designated purchaser upon payment from Medicaid;
 14. The OCDD Central Office forwards the reimbursements to the designated purchaser upon payment from Medicaid; and
 15. All billing must be completed by the POC end date in order for the reimbursement to be paid. OCDD Central Office Fiscal Section maintains documentation for accounting and monitoring purposes of each beneficiary’s TEPA request including original receipts and record of payments to the designated purchaser.

Additional requests for one time transitional expenses must be requested by the beneficiary and submitted by the support coordinator on a new TEPA request form to LGE following the above

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procedure. Requests must be approved 60 calendar days prior to the expiration of the original POC.

Changes in Service Needs

All requests for changes in services and/or service hours must be made by the beneficiary or their personal representative.

Changing Direct Service Providers

Beneficiaries may change DSPs once every service authorization quarter (3 months) with the effective date being the beginning of the following quarter. DSPs may be changed for good cause at any time as approved by the LGE.

Good cause is defined as:

1. A beneficiary moving to another region in the state where the current DSPs does not provide services;
2. The beneficiary and the DSP have unresolved difficulties and mutually agree to a transfer;
3. The beneficiary would like to share supports with another beneficiary who has a different provider agency, regardless of the beneficiary's relationship;
4. The beneficiary's health, safety or welfare have been compromised; or
5. The DSP has not rendered services in a manner satisfactory to the beneficiary or their authorized representative.

Beneficiaries and/or their authorized representative must contact their support coordinator to change DSPs.

The support coordinator will assist in facilitating a support team meeting to address the beneficiary's reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider should have the opportunity to submit a corrective action plan with specific timelines, not to exceed 30 days, to attempt to meet the needs of the beneficiary.

If the beneficiary/authorized representative refuses a team meeting, the support coordinator and LGE determine that a meeting is not possible or appropriate, or the corrective action plan and timelines are not met, the support coordinator will:

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1. Provide the beneficiary/ authorized representative with a current FOC list of service providers in their region;
2. Assist the beneficiary/authorized representative in completing the FOC list and release of information form;
3. Ensure the current provider agency is notified immediately upon knowledge and prior to the transfer; and
4. Obtain the case record from the releasing provider, which must include:
 - a. Progress notes from the last 2 months, or if the beneficiary has received services from the provider for less than 2 months, all progress notes from date of admission;
 - b. Written documentation of services provided, including monthly and quarterly progress summaries;
 - c. Current POC provider documents;
 - d. Records tracking beneficiary’s progress towards individualized service plan (ISP) goals and objectives, including standardized vocational assessments and/or notes regarding community or facility-based work assessments, if applicable;
 - e. Records of job assessment, discovery, and development activities which occurred, and a stated goal and objective in the most current ISP for the beneficiary to obtain competitive work in the community, if stated;
 - f. Copies of current and past behavior management plans, if applicable;
 - g. Documentation of the amount of authorized services remaining in the POC including applicable time sheets; and
 - h. Documentation of exit interview.

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The support coordinator will forward copies of the following to the new service provider:

1. Most current POC;
2. Current assessments on which the POC is based;
3. Number of services used in the PA periods for the current POC year;
4. Records from the previous service provider; and
5. All other waiver documents necessary for the new service provider to begin providing service.

Transfers must be made 7 days prior to the end of the service authorization quarter in order to coordinate services and billing, unless the LGE waives this requirement in writing due to good cause.

The new service provider must bear the cost of copying, which cannot exceed the community's competitive copying rate. If the existing provider charges a rate that exceeds the competitive copying rate, then the provider should contact the support coordinator to resolve the issue.

Prior Authorization for New Service Providers

New providers who provide services prior to the start date on the new PA will not be reimbursed.

A new PA number will be issued to the new provider with an effective starting date of the first day of the new quarter or date agreed to by the new provider. The transferring agency's PA number will expire on the date immediately preceding the PA date for the new provider. New providers who provide services prior to the begin date of the new PA period will not be reimbursed.

Exceptions to the existing service provider end date and the new service provider begin date may be approved by the LGE when the reason for change is due to good cause.

Changing Support Coordination Agencies

A beneficiary may change support coordination agencies after a 6-month period or at any time for good cause if the new agency has not met its maximum number of beneficiaries. Good cause is defined as:

1. A beneficiary moving to another region in the state;

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2. The beneficiary and the support coordination provider have unresolved difficulties and mutually agree to a transfer;
3. The beneficiary's health, safety or welfare have been compromised; or
4. The support coordination provider has not rendered services in a manner satisfactory to the beneficiary.

Participating support coordination agencies should refer to the Case Management Services manual chapter in the *Louisiana Medicaid Provider Manual* which provides a detailed description of their roles and responsibilities.

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PROVIDER REQUIREMENTS

All home and community-based services (HCBS) delivered through a 1915(c) waiver must be provided in accordance with the following qualities:

1. Integrated in and supports access to the greater community;
2. Provide opportunities to seek employment and work in competitive and integrated settings, engage in community life and control personal resources;
3. Ensures that the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS services;
4. Allow for a setting selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting;
5. Ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint;
6. Optimize individual initiative, autonomy and independence in making life choices; and
7. Facilitate individual choice regarding services and supports and who may provide said services and supports.

In addition to the above qualities, residential provider-owned/controlled settings must have the following qualities:

1. The specific unit/dwelling must be owned, rented, or occupied under a legally enforceable agreement/lease;
2. Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, parish, city or other designated entity;
3. If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
4. Each individual has privacy in their sleeping or living unit;
5. Units have lockable entrance doors, with the individual and appropriate staff members having keys to doors as needed;
6. Individuals who are sharing units have a choice of roommates;

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7. Individuals have the freedom to furnish and decorate their sleeping or living units within the limits imposed by the lease or other agreement;
8. Individuals have the freedom and support to control their schedules and activities and have access to food at any time;
9. Individuals may have visitors at any time; and
10. The setting is physically accessible to the individual.

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid waiver program, a provider must:

1. Meet all of the requirements for licensure as established by state laws and rules promulgated by the Louisiana Department of Health (LDH – Health Standards Section (HSS));
2. Agree to abide by all rules and regulations established by the Centers for Medicare and Medicaid Services (CMS), LDH, and other state agencies, if applicable;
3. Comply with all the terms and conditions for Medicaid enrollment; and
4. Follow the expectations of the *HCBS Settings Rule*, issued 3/17/2014.

It is the provider’s responsibility to:

1. Ensure, on an annual basis, that they remain in compliance with the HCBS Settings Rule by signing an attestation form;
2. Attend all mandated meetings and training sessions as directed by the Office for Citizens with Developmental Disabilities (OCDD) or the local governing entity (LGE) as a condition of enrollment and continued participation as a waiver provider. A provider enrollment packet must be completed for each LDH administrative region in which the agency will provide services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number;
3. Providers must participate in the initial training for prior authorization (PA) and data collection and any training provided on changes in the system. Initial training is provided at no cost to the agency. Any repeat training must be paid for by the requesting agency;
4. Have available computer equipment, software, and internet connectivity necessary to participate in PA, data collection, and electronic visit verification (EVV);

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5. Ensure that use of contractors, including the use of independent contractors, complies with all state and federal laws, rules and/or regulations, including those enforced by the United States Department of Labor;
6. Maintain a toll-free telephone line with 24-hour accessibility manned by a staff member or by an answering service. This toll-free number must be given to beneficiaries at intake or at the first meeting. Brochures providing information on the agency's experience must include the agency's toll-free number along with the OCDD's toll-free information number. OCDD must approve all brochures prior to use; and
7. Develop a quality improvement and self-assessment plan. This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. The first self-assessment is due 6 months after approval of the Quality Improvement Plan (QIP) and yearly thereafter.

The QIP must be submitted for approval within 60 days after the training is provided by LDH.

Providers must be certified for a period of one year. Re-certification must be completed no less than 60 days prior to the expiration of the certification period.

The agency must not be excluded from participation as an entity as evidenced by an open exclusion on the Louisiana State Adverse Actions database, the Office of Inspector General's (OIG) national exclusions database, or the federal System for Award Management (SAM) database.

The agency must not be excluded from participation as an entity as evidenced by an open exclusion on the Louisiana State Adverse Actions database, the OIG national exclusions database, or the federal SAM database. The agency must not have an outstanding Medicaid program audit exception or other unresolved financial liability owed to the state.

Changes in the following areas are to be reported to the Office of the Secretary's Bureau of Health Services Financing (BHSF) Health Standards Section (HSS), to OCDD, and to the fiscal intermediary's (FI's) Provider Enrollment section in writing at least 10 days prior to any change:

1. Ownership;
2. Physical location;
3. Mailing address;
4. Telephone number; and/or
5. Account information affecting electronic funds transfer (EFT).

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The provider must complete a new provider enrollment packet when a change in ownership of five percent to 50 percent of the controlling interest occurs, but the provider may continue serving beneficiaries. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur, and the agency shall not continue serving beneficiaries until the re-certification process is complete.

When a provider closes or decides to no longer participate in the Medicaid program, the provider must give at least a 30-day written advance notice to all beneficiaries served and their responsible representative, support coordination agencies, and LDH (OCDD and HSS—if licensed) prior to discontinuing services.

Waiver services are to be provided only to persons who are waiver beneficiaries and strictly in accordance with the provisions of the approved plan of care (POC).

Providers may not refuse to serve any waiver beneficiary that chooses their agency unless there is documentation to support an inability to meet the individual's health, safety, and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. Such refusal to serve an individual must be put in writing by the provider and include a detailed explanation as to why the provider is unable to serve the individual. Written notification must be submitted to the LGE. Providers who contract with other entities to provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver beneficiary referred to it by the enrolled direct service provider (DSP) agency.

An HCBS provider shall provide a written notice of involuntary transfer or discharge with appeal rights to the client, a family member of the client, if known, to the authorized representative if known, and the support coordinator, at least 30 days prior to the transfer or discharge.

The beneficiary's provider and support coordination agency must have a written working agreement that includes the following:

1. Written notification of the time frames for POC planning meetings;
2. Timely notification of meeting dates and times to allow for provider participation;
3. Information on how the agency is notified when there is a POC or service delivery change; and
4. Assurance that the appropriate provider representative is present at planning meetings as invited by the beneficiary.

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ROW services outlined below may be provided by the provider or by an agreement with other contracted agents. The actual provider of the service, whether it is the provider or a subcontracted agent, must meet the following licensure or other qualifications:

Waiver Service	Requirements	Service Provided by
<p>Support Coordination</p>	<p>Case Management License</p> <p>Providers of support coordination for the ROW program must have a signed performance agreement with OCDD to provide services to waiver beneficiaries.</p> <p>Support coordination agencies must meet all of the performance agreement requirements, state rules and <i>ROW Provider Manual</i>.</p>	<p>Enrolled agency Provider Type 45: Case Management-Contract</p> <p>Specialty 81: Case Management</p> <p>Subspecialty: 4W</p>
<p>Community Living Supports</p>	<p>HCBS Provider License (Personal Care Attendant Module)</p> <p>Self-Direction Option Available</p>	<p>Enrolled agency Provider Type 82: Personal Care Attendant</p> <p>Specialty 82: Personal Care Attendant</p> <p>Subspecialty: 4W</p>
<p>Companion Care</p>	<p>Personal Care Attendant Module</p>	<p>Enrolled agency Provider Type 82: Personal Care Attendant</p> <p>Specialty 82: Personal Care Attendant</p> <p>Subspecialty: 4W</p>
<p>Shared Living</p>	<p>Supervised Independent Living Module Supervised Independent Living Conversion Module</p> <p>Shared Living Providers must also have OCDD approval which includes:</p> <ol style="list-style-type: none"> 1. Conversion Option: <ol style="list-style-type: none"> a. Current ICF/IID provider in good standing and licensed to operate by LDH-Health Standards Section (Conversion Module); b. Apply for and meet ROW provider qualifications for the Shared Living Conversion; and c. OCDD regional office will document that the Shared Living option was explained to, understood by, and agreed upon by all 	<p>Enrolled agency Provider Type 11: Shared Living</p> <p>Specialty 4A: DD</p> <p>Subspecialties: <u>Conversion Option:</u> 4J-Provider Owned/Leased Residence 4H- Beneficiary Owned/Leased Residence</p> <p><u>New Option:</u></p>

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	<p>individuals who will be affected when the ICF/IID is closed and the license is surrendered.</p> <p>2. New Option:</p> <p>a. If any ICF/IID license is held or was previously held, the licensee must be or have been a provider in good standing; and</p> <p>b. Apply for and meet ROW provider qualifications for the Shared Living.</p>	<p>4G-Provider Owned/Leased Residence 4L- Beneficiary Owned/Leased Residence</p>
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One Time Transitional Expenses		OCDD
<p>Host Home</p>	<p>Substitute Family Care Module when providing services to adults</p> <p>Class “A” Child Placing License when providing services to children</p> <p>Providers must:</p> <ol style="list-style-type: none"> 1. Have experience in delivering therapeutic services to persons with developmental disabilities; and 2. Have staff who have experience working with persons with developmental disabilities. 	<p>Enrolled agency Provider Type 84: Substitute Family Care</p> <p>Specialty 84: Substitute Family Care</p> <p>Subspecialty: 4W</p>
<p>Center Based Respite</p>	<p>HCBS Provider License Respite Care Module for a facility</p>	<p>Enrolled agency Provider Type 83: Waiver-Respite Care</p> <p>Specialty 83: Respite Care</p>
<p>Environmental Accessibility Adaptations</p>	<p>Home Adaptations:</p> <p>Providers must be registered through the Louisiana State Licensing Board for Contractors as a General Contractor, Home Improvement Contractor, or Residential Building Contractor.</p> <p>Environmental Modification providers must meet the following requirements:</p> <ol style="list-style-type: none"> 1. Must be enrolled as a Medicaid Environmental Modifications Provider; 2. Must comply with all applicable Local (City or Parish) Occupational License(s); 	<p>Enrolled agency Provider Type 15: Environmental Modifications</p> <p>Specialty 80: Environmental Modifications</p>

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	<ol style="list-style-type: none"> 3. All services shall be provided in accordance with applicable State or local requirements; 4. Must meet any state or local requirements for licensure or certification for the work performed, as well as the person performing the service (i.e., building contractors, plumbers, electricians, or engineers); 5. Must meet such standards for modifications to the home when state and local building or housing code standards are applicable; and 	
	<p>Vehicle Adaptations/Vehicle Lift</p> <p>Providers must be currently licensed as a specialty vehicle with accreditation for Structural Vehicle Modifier in the state licensure.</p> <p>Vehicle modification providers must meet the following requirements:</p> <ol style="list-style-type: none"> 1. Must be enrolled as a Medicaid environmental modifications provider; 2. Must comply with all applicable local (city or parish) occupational license(s); and 3. All services shall be provided in accordance with applicable State or local requirements. 	
<p>Assistive Technology/Specialized Medical Equipment and Supplies</p>	<p>Must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.</p>	<p>Enrolled agency Provider Type 17: Assistive Devices</p> <p>Specialty 91: Assistive Devices</p>

<p>Personal Emergency Response Systems</p>	<p>Must meet all applicable vendor requirements, federal, state, parish and local laws for installation.</p>	<p>Enrolled agency Provider Type 16: Personal Emergency Response Systems</p> <p>Specialty 90: Personal Emergency Response Systems (Waiver)</p>
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<p>Transportation-Community Access</p>	<p>Must maintain the state minimum automobile liability insurance coverage, have a current state inspection sticker, and have a current valid driver’s license.</p>	<p>Enrolled agency Provider Type 42: Friends and Family</p> <p>Specialty: 4W</p> <p>Subspecialty: 4W</p>
<p>Professional Services</p>	<p>Must possess a current valid Louisiana license to practice in the following fields of expertise:</p> <ol style="list-style-type: none"> 1. Registered dietician; 2. Speech therapist; 3. Occupational therapist; 4. Physical therapist; 5. Social worker; and 6. Psychologist. <p>Professionals are able to enroll individually and/or be linked to an agency. Professionals must have one-year experience in delivering services to persons with developmental disabilities based on the following criteria:</p> <ol style="list-style-type: none"> 1. Verification that every professional meets the one-year experience requirement for delivering services to persons with developmental disabilities; 2. Full-time employment gained in advanced and accredited training programs (i.e., masters or residency level training programs) which includes services for persons with developmental disabilities); 3. Paid, full-time professional experience in specialized service/treatment settings for persons with developmental disabilities (i.e., intermediate care facilities for persons with developmental disabilities); 4. Paid, full-time professional experience in multi-disciplinary programs for persons with developmental disabilities (i.e., mental health treatment programs for persons with dual diagnosis-mental illness and developmental disabilities); 5. Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with developmental disabilities (i.e., school special education program); and 	<p>Enrolled agency</p> <p>Employed or contracted by Home and Community-Based Service Provider (Personal Care Attendant Module, Supervised Independent Living Module or Home Health agency</p> <p>Individual Enrollment</p> <p>Provider Type 41: Registered Dietician Specialty 4R: Registered Dietician</p> <p>Provider Type 39: Speech Therapist Specialty 71: Speech Therapy</p> <p>Provider Type 37: Occupational Therapist Specialty 74: Occupational Therapy</p> <p>Provider Type 35: Physical Therapist Specialty 65:</p>

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	<p>6. Two years of part-time experience (minimum of 20 hours per week) may be substituted for one year of full-time experience.</p> <p>Items that do not qualify for the required experience:</p> <ol style="list-style-type: none"> 1. Volunteer professional experience; and 2. Experience gained in caring for a relative or friend with developmental disabilities. <p>If a professional chooses to link to an agency, the agency must be licensed by the LDH as one of the following:</p> <ol style="list-style-type: none"> 1. Home health agency; 2. Free-standing rehabilitation clinic; 3. Supervised independent living agency (shared living); 4. Substitute family care (host home-adult); or 5. Class “A” child placing agency (host home-child) by the Department of Children and Family Services. 	<p>Individual Physical Therapy</p> <p>Provider Type 73: Social Worker Specialty 73: Social Work</p> <p>Provider Type 31: Psychologist Specialty 62: Psychologist (Crossovers Only) Specialty 95: Psychologist (PBS Program Only) Specialty 96: Psychologist (PBS Program and Crossovers)</p> <p>For All Professionals: Subspecialty: 4W</p> <p>Individual Professionals can link to:</p> <p>Provider Type 11: Shared Living and/or Provider Type 84: Substitute Family Care</p>
<p>Nursing</p>	<p>Registered nurse and licensed practical nurse: must meet Louisiana licensing requirements</p> <p>Nurses are only able to provide services by linking to an agency. The agency must be licensed by the LDH as one of the following:</p> <ol style="list-style-type: none"> 1. Home health agency; or 2. Shared living (only subspecialty-conversion). <p>Nurses must have one-year experience delivering services to persons with developmental disabilities. OCDD requires verification that every professional meets the one-year</p>	<p>Enrolled agency Must be linked to: Provider Type 11: Shared Living Agency (only w/Subspecialty 4H and/or 4J) or Provider Type 44: Home Health Agency</p> <p>Specialty 87: All Other</p>

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	<p>experience requirement for delivering services to persons with developmental disabilities based on the following criteria:</p> <ol style="list-style-type: none"> 1. Full-time experience gained in advanced and accredited training programs (i.e., masters or residency level training programs) which includes treatment services to persons with developmental disabilities); 2. Paid, full-time experience in specialized service/treatment services for persons with developmental disabilities (i.e., intermediate care facilities for persons with developmental disabilities); 3. Paid, full-time nursing experience in multi-disciplinary programs for persons with developmental disabilities (i.e., mental health treatment programs for persons with dual diagnosis-mental illness and developmental disabilities); or 4. Paid, full-time nursing experience in specialized education, vocational and therapeutic programs or settings for persons with developmental disabilities (i.e., school special education program). <p>NOTE: Two years of part-time experience (minimum of 20 hours per week) may be substituted for one year of full-time experience.</p> <p>Activities not included toward the required experience include:</p> <ol style="list-style-type: none"> 1. Volunteer nursing experience; and 2. Experience gained by caring for a relative or friend with developmental disabilities. 	<p>Subspecialty: 4W</p>
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<p>Supported Employment (individual/group)</p>	<p>Individual SE: Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services or Certificate of Completion from an approved 40 hour core Supported Employment Training and 15 hours of annual employment related training plus a HCBS Provider License (Provider Type 98-Supported Employment Module)</p> <p>Group Employment: Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services; or an approved 40- hour core Supported Employment training with 15 hours of annual employment related training</p> <p>OR</p>	<p>Enrolled agency Provider Type 98: Habilitative Supportive Employment</p> <p>Specialty 98: Supported Employment</p>
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	Adult Day Care License with license Module 98 with annual 15 hours of employment related training.	
Prevocational Services	HCBS Provider License (Adult Day Care license, Provider Type Module 14)	Enrolled agency Provider Type 13: Prevocational Habilitation Specialty 36: Prevocational Habilitation
Day Habilitation	HCBS Provider License (Adult Day Care license, Provider Type Module 14)	Enrolled agency Provider Type 14: Adult Day Habilitation Specialty 50: Day Habilitation
Community Life Engagement Development	HCBS Provider License (Adult Day Care license, Provider Type Module 14)	Enrolled agency Provider Type 14: Adult Day Habilitation

Adult Day Health Care (ADHC)	HCBS Provider License (Adult Day Center Module) NOTE: Qualifications for ADHC staff are set forth in the licensing regulations found in the Louisiana Administrative Code.	Enrolled agency Provider Type 85: Adult Day Health Care Specialty 35: Adult Day Health Care Subspecialty: 4W
Monitored In Home Caregiving	HCBS Provider License (Monitored In-Home Caregiving Module)	Enrolled agency Provider Type MI Monitored In- Home Caregiving Specialty 35: Monitored In- Home Caregiving

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When required by state law, the person performing the service, such as building contractors, plumbers, electricians, or engineers, must meet applicable requirements for professional licensure and modifications to the home and must meet all applicable building code standards.

A provider is able to enroll and select up to 3 sub-specialties per one provider number. For example, if a shared living provider wishes to enroll and provide all 4 subspecialties, 2 separate provider numbers will need to be obtained.

Provider Responsibilities for All Providers

All providers of ROW services are responsible for the following:

1. Ensuring an appropriate representative from the agency attends the quarterly and annual POC meeting and is an active participant in the team meeting;

NOTE: An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the beneficiary's service delivery. This person may be a program manager, a direct services professional, case supervisor, or the executive director or designee. An unlicensed direct service worker who works with or will work with the beneficiary is not considered an appropriate representative for the POC planning meeting.

2. Communicating and working with support coordinators and other support team members to achieve the beneficiary's personal outcomes;
3. Ensuring the provider POC documents are updated as changes occur, including the beneficiary's emergency contact information and list of medications and kept current;
4. Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or timelines in the POC will not meet the beneficiary's needs, but not later than 10 days prior to the expiration of any timelines in the service plan that cannot be met;
5. An update to the provider's document should only occur as a result of a documented meeting with the beneficiary or authorized representative where the reason for change is indicated and all parties sign the meeting attendance record;
6. Ensuring the provider agency support team member(s) sign and date any revisions to the service plan indicating agreement with the changes to the goals, objectives, or time lines;

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7. Providing the support coordination agency or LDH representatives with requested written documentation including, but not limited to:
 - a. Completed, signed, and dated service plan;
 - b. Service logs, progress notes, and progress summaries;
 - c. Direct service worker (DSW) attendance and payroll records;
 - d. Written grievances or complaints filed by beneficiaries/family;
 - e. Critical or other incident reports involving the beneficiary; and
 - f. Entrance and exit interview documentation.
8. Explaining to the beneficiary/family in their native language the beneficiary rights and responsibilities within the agency;
9. Assuring that beneficiaries are free to make a choice of providers without undue influence;
10. Ensuring that the provider agency is in compliance with the expectations as set forth in the *HCBS Settings Rule* and following the guidance provided; and
11. HCBS providers will sign an annual attestation form stating that they continue to meet the expectations of the *HCBS Settings Rule*.

Note: It is the policy of LDH, OCDD that all critical incidents for HCBS be reported, investigated and tracked. The statewide incident management system MUST be used for ALL critical incident reporting.

Support Coordination

Support coordination is a service that will assist beneficiaries in gaining access to all of their needed support services, including medical, social, educational, and other services, regardless of the funding source for the services.

Support Coordination Providers

Providers of support coordination for the ROW program must have a signed performance agreement with OCDD to provide services to waiver beneficiaries. Support coordination agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined by OCDD.

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Support coordination activities include, but are not limited to the following:

1. Convening the person-centered planning team comprised of the beneficiary, beneficiary's family, DSPs, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies needed in order to meet the beneficiary's needs and preferences;
2. On-going coordination and monitoring of supports and services included in the beneficiary's approved POC;
3. Building and implementing the supports and services as described in the POC;
4. Assisting the beneficiary to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the beneficiary in the POC;
5. Providing information to the beneficiary on potential community resources, including formal resources and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining their desired personal outcomes;
6. Assisting with coordinating transportation to access medical services and community resources;
7. Assisting with problem solving with the beneficiary, families, services providers, and/or the LGE;
8. Assisting the beneficiary to initiate, develop, and maintain informal and natural support networks and to obtain the services identified in the POC, assuring that they meet their individual needs;
9. Advocating on behalf of the beneficiary to assist them in obtaining benefits, supports or services, i.e. to help establish, expand, maintain, and strengthen the beneficiary's information and natural support networks. This may involve calling and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;
10. Training and supporting the beneficiary in self-advocacy, i.e. the selection of providers and utilization of community resources to achieve and maintain their desired outcomes;
11. Oversight of the service providers to ensure that their beneficiary receives appropriate services and outcomes as designated in the POC;

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12. Assisting the beneficiary to overcome obstacles, recognize potential opportunities, and developing creative opportunities;
13. Meeting with the beneficiary in face-to-face meetings, as well as via telephone contact, as specified. This includes meeting the beneficiary where the services take place;
14. If criteria are met, virtual visits are permitted; however, the initial and annual POC meeting and at least one other meeting per year must be conducted face to face;
15. When a relative is living in the home or a legally responsible individual or legal guardian provides a paid ROW service, all support coordination visits must be conducted face-to-face, with no option for virtual visits;
16. Reporting and documenting any incidents/complaints/abuse/neglect according to the OCDD policy and in accordance with licensure, state laws, rules, and regulations, as applicable;
17. Arranging any necessary professional/clinical evaluations needed and ensuring beneficiary choice;
18. Identifying, gathering, and reviewing the array of formal assessments and other documents that are relevant to the beneficiary’s needs, interests, strengths, preferences, and desired personal outcomes;
19. Developing an action plan in conjunction with the beneficiary to monitor and evaluate strategies to ensure continued progress toward the beneficiary’s personal outcomes; and
20. On-going discussions with the beneficiary (16 years of age and older) about employment including:
 - a. Identifying barriers to employment and working to overcome those barriers, connecting the beneficiary to certified work incentive coordinators (CWIC) to do benefits planning;
 - b. Referring the beneficiary to Louisiana Rehabilitation Services (LRS); and
 - c. Following the case through closure with LRS, and other activities of the employment process as identified, including the quarterly completion of data input using the Path to Employment form.

NOTE: Advocacy is defined as assuring that the beneficiary receives appropriate supports and services of high quality and locating additional services not readily available in the community.

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Support Coordination Providers Qualifications

Support Coordination providers must meet the following requirements:

1. Be licensed as a support coordination provider; and
2. Meet all requirements as outlined in the *Support Coordination Performance Agreement*.

NOTE: Please refer to the Guidelines for Support Planning, Operational Instruction for Critical Incident Review, and OCDD Support Coordination Reference Guide for additional information.

Provider Responsibilities for All Residential Care Service Providers

DSP agencies must have written policy and procedure manuals that include; but, are not limited to the following:

1. Training policy that includes orientation and staff training requirements according to the LDH – HSS - HCBS Providers Licensing Standards, the DSW Registry, and the Class A Child Placing Licensing Standards (as applicable to specific residential service being provided);
2. Direct care abilities, skills, and knowledge requirements that employees must possess to adequately perform care and assistance as required by waiver beneficiaries;
3. Employment and personnel job descriptions, hiring practices including a policy against discrimination, employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances, staffing, and staff coverage plan;
4. Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal;
5. Identification, notification, and protection of beneficiary’s rights both verbally and in writing in a language that the beneficiary/family is able to understand;
6. Written grievance procedures;
7. Information about abuse and neglect as defined by LDH regulations and state and federal laws;
8. EVV: requirements/proper use of check in/out; acceptable editing of electronically captured services; reporting services when in “no service zones” or failure to clock

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in/out (Electronic Connectivity form and manual entry); confidentiality of log in information; monitoring of EVV system for proper use;

9. DSW Registry: requirement for accessing the department's Adverse Action database for findings placed against the direct service workers prohibiting employment;
10. Criminal history checks: requirement for compliance with state statutes for non-licensed direct care personnel; and
11. Medicaid has established a DSW wage floor. Provider agencies must follow these rules and pay the DSW as directed by Medicaid. The current wage floor can be found in the Louisiana Administrative Code and OCDD will post a memo on the OCDD website. Providers will be responsible for following this directive.

POC Provider Documents

The DSP must complete the provider portion of the POC to include all waiver services that the agency provides to the beneficiary based on the beneficiary's identified POC goals and other supports required.

The provider documents in the POC must be person-centered, focused on the beneficiary's desired outcomes, and include the following elements:

1. Specific goals matching the goals outlined in the beneficiary's approved POC;
2. Measurable objectives and timelines to meet the specified goals and strategies to meet the objectives;
3. Identification of the DSP staff and any other support team members who will be involved in implementing the strategies; and
4. The method that will be used to document and measure the implementation of specified goals and objectives.

The POC provider documents must be reviewed and updated as necessary to comply with the specified goals, objectives, and timelines stated in the beneficiary's approved POC or when changes are necessary based on beneficiary needs.

Back-up Planning

DSPs are responsible for providing all necessary staff to fulfill the health and welfare needs of the beneficiary when paid supports are scheduled to be provided. This also includes times when the scheduled DSW is absent, unavailable or unable to work for any reason.

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All DSPs are required to develop an individualized back-up plan for each beneficiary that includes detailed strategies and person-specific information that addresses the specialized care and supports needed by the beneficiary.

DSPs are required to:

1. Have policies in place which outline the protocols that the agency has established to assure that back-up DSWs are readily available;
2. Ensure that lines of communication and chain of command procedures have been established; and
3. Have procedures for dissemination of the back-up plan information to beneficiaries, their authorized representatives, and their support coordinators.

Protocols must also describe how and when the direct support staff will be trained in the care needed by the beneficiary. This training must occur prior to any direct support staff member being solely responsible for a beneficiary.

Back-up plans must be updated as changes occur and at least annually to assure that the information is kept current and applicable to the beneficiary's needs. The back-up plan must be submitted to the beneficiary's support coordinator in a timely manner to be included as a component of the beneficiary's initial and annual POC.

DSPs may not use the beneficiary's informal support system as a means of meeting the agency's individualized back-up plan and/or emergency evacuation response plan requirements without documented consent of the informal support system. The beneficiary's family members and others identified in the beneficiary's circle of support may elect to provide backup, but this does not exempt the provider from the requirement of providing the necessary staff for backup purposes when paid supports are scheduled.

Emergency Evacuation Planning

Emergency evacuation plans must be developed in addition to the beneficiary's individualized back-up plan. Providers must have an emergency evacuation plan that specifies in detail how the DSP will respond to potential emergency situations such as fires, hurricanes, tropical storms, hazardous material release, flash flooding, ice storms, and terrorist attacks.

The emergency evacuation plan must be person-specific and include at a minimum the following components:

1. Individualized risk assessment of potential health emergencies;

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2. A detailed plan to address the beneficiary’s individualized evacuation needs, including a review of the beneficiary’s individualized back-up plan, during geographical and natural disaster emergencies and all other potential emergency conditions;
3. Policies and procedures outlining the agency’s implementation of emergency evacuation plans and the coordination of these plans with the local Office of Emergency Preparedness and Homeland Security;
4. Establishment of effective lines of communication and chain of command procedures;
5. Establishment of procedures for the dissemination of the emergency evacuation plan to beneficiaries and support coordinators; and
6. Protocols outlining how and when DSWs and beneficiaries will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

Training for DSWs and surety of competency must occur prior to the worker being solely responsible for the support of the beneficiary.

The beneficiary must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

OCDD, support coordination agencies, and DSP agencies are responsible for following the established emergency protocol before, during, and after hurricanes or other natural disasters or events as outlined in the “Emergency Protocol for Tracking Location Before, During, and After Hurricanes” document found in the OCDD Guidelines for Support Planning manual. (Refer to Appendix D for website information).

Host Home Provider Responsibilities

The Host Home provider is responsible for screening, training, overseeing, and providing technical assistance to Host Home families in accordance with OCDD requirements, including the coordination of medical, behavioral, and other professional services geared to persons with developmental disabilities.

Host Home providers must provide on-going assistance to Host Home families so that all HCBS waiver health and safety assurances, monitoring, and critical incident reporting requirements are met. The Host Home provider and the Host Home family are required to participate in the POC process and follow the POC as indicated.

Host Home providers are responsible for:

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1. Assisting in the selection of Host Home families (determining suitable matches between Host Home families and Host Home beneficiaries);
2. Inspecting the home setting, completing reference checks on each person in the home (criminal record and background checks), conducting a home study, verifying that Host Home family has a stable income sufficient to meet routine expenses independent of ROW service payments, and making a certification determination of prospective Host Home families;
3. Developing contracts with Host Home families;
4. Participating in the development of the beneficiary's POC;
5. Providing and/or arranging routine and specialized training specific to the needs of the beneficiary;
6. Providing ongoing follow-up and oversight of Host Home families to ensure that the POC is being followed (including the documentation and maintenance of data and records), that the services being provided meet quality standards, that there is continuity of services, and that the home environment continues to be a safe and suitable environment;
7. Providing emergency services as needed;
8. Providing 24-hour oversight and supervision of Host Home services, including approved alternative supports, and supervision as identified in the approved POC; and
9. Providing Host Home family relief supports (scheduled and unscheduled relief) during absences of the Host Home Family with the following guidelines:
 - a. Limited to 360 hours (15 days) per POC year as indicated in the POC;
 - b. Relief staff for scheduled and unscheduled absences are included in the Host Home provider's rate;
 - c. Relief staff for scheduled and unscheduled absences may be provided either in the Host Home family setting or at a location of the beneficiary's choosing, but must be indicated in the POC;
 - d. The beneficiary (or if the beneficiary is a minor, the beneficiary's legal representative) may agree to have the beneficiary reside with another Host Home family;

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- e. Regardless of where the Host Home services are provided, the Host Home provider is responsible for oversight, supervision, and back-up of the Host Home service; and
- f. Assuring that only persons approved in accordance with licensing regulations are allowed to provide services to or reside in the same residence as the beneficiary.

Host Home families are responsible for:

1. Participating with the Host Home provider during the selection of Host Home families (determination of families as a suitable match for Host Home beneficiaries);
2. Being available during inspections of the home setting, participating in a home study, and complying with all activities conducted by the Host Home provider in the determination process;
3. Participating in the Host Home provider’s contract development for the Host Home family;
4. Participating in routine and specialized training specific to the needs of the beneficiary;
5. Participating in the development of the beneficiary’s POC;
6. Following the beneficiary’s POC and providing any specialized supports as specified in the POC;
7. Providing assistance to ensure that the beneficiary has access to community services/activities and assistance in the development of community recreational and social interests;
8. Providing assistance to the beneficiary in keeping medical appointments, therapy appointments, and other appointments necessary for the health and well-being of the beneficiary;
9. Providing or arranging appropriate transportation to school, work, medical appointments, therapy appointments, and other appointments/activities necessary for the health and well-being of the beneficiary;
10. If indicated in the POC, the Host Home family will support the beneficiary in maintaining contact with their biological family and/or natural supports;

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11. Providing unpaid supports when the beneficiary is either working or interested in working;
12. Maintaining adequate records to substantiate service delivery and producing such records upon request;
13. Maintaining data to assist in the evaluation of the beneficiary's personal goals as identified in the POC and producing such records upon request; and
14. Immediately reporting to the Host Home provider any major issues or concerns related to the beneficiary's safety and well-being.

Host Home Services (Provided to Children)

Host Home families who provide serves to children are required to provide daily supports and supervision on a 24-hour basis in order to:

1. Meet the on-going support needs of the beneficiary; and
2. Handle emergencies as any family would do for its minor child as required based on age, capabilities, health conditions, and special needs.

Providers serving children or adults in the Host Home setting must meet the following requirements:

1. Have experience in delivering therapeutic services to persons with developmental disabilities;
2. Have staff who have experience working with persons with developmental disabilities;
3. Screen, train, oversee, and provide technical assistance to Host Home families in accordance with OCDD requirements, including the coordination of medical, behavioral, and other professional services geared to persons with developmental disabilities; and
4. Provide on-going assistance to Host Home families so that all HCBS waiver health and safety assurances, monitoring, and critical incident reporting requirements are met.

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Host Home Services (Provided to Adults)

Host Home families who serve adults who have been interdicted must ensure that services are furnished in accordance with the legal requirements of the interdiction and must assist in providing information to supervisory authorities.

Host Home Families Employed Outside of the Home

Host Home families who are employed outside of the home must adjust their employment/business duties/responsibilities to allow for the flexibility needed to meet their responsibilities to the beneficiary.

Companion Care Provider Responsibilities

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

1. Types of support provided by the companion;
2. Activities provided by the companion;
3. A typical weekly schedule;
4. Assisting in the selection of companions who would be a suitable match for each beneficiary;
5. Participating in the development of the beneficiary's POC;
6. Facilitating in the development of the beneficiary/companion agreement;
7. Ensuring that the POC is being followed;
8. Conducting an initial inspection as well as periodic inspections of the beneficiary's home;
9. Providing all required training to companions, including any training specific to the special needs of the beneficiary; and
10. Contacting the companion a minimum of once per week or more, if specified in the POC.

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

1. Arranging the delivery of services and providing emergency services;
2. Making an initial home visit to the beneficiary's home, as well as periodic home visits, as required by the department;
3. Contacting the beneficiary/companion a minimum of once per week or as specified in the beneficiary's comprehensive POC;
4. Providing 24-hour oversight, back-up, and supervision of the companion care services, including back-up for the scheduled and unscheduled absences of the companion;
5. Providing emergency services;
6. Providing Companion Care relief supports (scheduled and unscheduled relief) during absences of the companion with the following guidelines:
 - a. Limited to 360 hours (15 days) per POC year as indicated in the POC;
 - b. Relief staff members or scheduled and unscheduled absences are included in the Companion Care rate; and
 - c. The Companion Care provider is responsible for oversight, supervision, and back-up of the companion care service.
7. Facilitating a signed written agreement between the companion and the beneficiary which assures:
 - 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 beneficiary and the companion. The provider must facilitate these negotiations, and the resulting agreement must be included in the written agreement and in the beneficiary's POC.

Responsibilities of the Companion

Responsibilities of the companion include:

1. Participating in the beneficiary's POC;

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2. Participating in the development of the beneficiary/companion agreement;
3. Maintaining records in accordance with OCDD and provider requirements; and
4. Following the POC and beneficiary/companion agreement, which includes:
 - a. Implementing the identified supports as indicated;
 - b. Assisting with activities of daily living as indicated;
 - c. Assisting the beneficiary in accessing community activities as indicated;
 - d. Being available as indicated and outlined in the pre-arranged time schedule as outlined;
 - e. Being available on short notice by telephone during crises situations as outlined; and
 - f. Coordinating transportation as needed.

Shared Living Provider Responsibilities

In addition to the aforementioned responsibilities, Shared Living providers must also have OCDD approval, which includes the following:

1. Conversion Option:
 - a. Current ICF/IID provider in good standing and licensed to operate by LDH-HSS;
 - b. Application for and meeting ROW provider qualifications for the Shared Living Conversion; and
 - c. Documentation by the LGE that the shared living option was explained to, understood by, and agreed upon by all individuals who will be affected when the ICF/IID is closed and its license is surrendered.
2. New Option:
 - a. If any ICF/IID license is held or was previously held, the licensee must be or have been a provider in good standing; and

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- b. Application for and meeting ROW provider qualifications for the Shared Living.

Day Habilitation Provider Responsibilities

The service provider must possess a current valid HCBS provider's license to provide adult day care services (ADHC) and adhere to the following requirements in order to provide transportation to beneficiaries.

The provider's vehicles used in transporting beneficiaries must adhere to the following requirements of the HCBS licensing rule:

1. Be in good condition and repair;
2. Have a current Louisiana inspection sticker; and
3. Have a first aid kit on board.

Providers must:

1. Maintain liability insurance in the amount specified in the HCBS licensing requirements;
2. Ensure drivers have a current Louisiana driver's license applicable to the vehicle being used;
3. Document this service in the beneficiary's record; and
4. Ensure the trip is documented in the provider's transportation log, which can be either electronic with GPS tracking or a paper log.

NOTE: The log is not required to be filed in the beneficiary's record file, but must contain information that identifies the beneficiary, the time of pick up, and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including LGE and support coordination.

Supported Employment Provider Responsibilities

Supported employment providers must maintain documentation in the file of each individual beneficiary that the services are not available to the beneficiary in programs funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401) (16 and 17) and those covered under the State Plan, if applicable.

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The service provider must possess a current valid HCBS Provider License (provider type 98 module) to provide supported employment services and in addition, for individual SE, a 40 hour core Supported Employment certificate and annual training OR be a valid LRS CRP.

For Group Employment, the provider can have a valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services; or complete an approved 40 hour core Supported Employment training with current annual employment related training or possess a valid Adult Day Care license, with Module 98 with annual 15 hours of employment related training. Providers must meet the following requirements in order to provide transportation to beneficiaries:

1. Vehicles used in transporting beneficiaries must adhere to the requirements of the HCBS licensing rule;
2. Drivers must have a current Louisiana driver's license applicable to the vehicle being used;
3. Vehicles used in transporting beneficiaries must:
 - a. Be in good condition and repair;
 - b. Have a current Louisiana inspection sticker;
 - c. Have a first aid kit on board.
4. The provider must document this service in the beneficiary's record, and the trip must be documented in the provider's transportation log, which can be either electronic with GPS tracking or a paper log.

NOTE: The log is not required to be filed in the beneficiary's record file, but must contain information that identifies the beneficiary, the time of pick up, and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including LGE and districts and support coordination.

Prevocational Provider Responsibilities

The provider must maintain documentation in the file of each individual beneficiary receiving prevocational services that the services are not available to eligible beneficiaries in programs funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602 (26) and (29) of the IDEA Act [20 U.S.C. 1401 (16) and (17)].

The service provider must adhere to the following requirements in order to provide transportation to beneficiaries:

1. The provider's vehicles used in transporting beneficiaries must:

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- a. Be in good condition and repair;
 - b. Have a current Louisiana inspection sticker; and
 - c. Have a first aid kit on board.
2. Drivers must have a current Louisiana driver’s license applicable to the vehicle being used; and
 3. The provider must document this service in the beneficiary’s record, and the trip must be documented in the provider’s transportation log.

Professional Services Provider Responsibilities (Psychological)

Providers of psychological services must:

1. Perform an initial evaluation to assess the beneficiary’s need for services;
2. Develop an individualized service plan (ISP) for the provision of psychological services, which must document the supports that will be provided to the beneficiary to meet their goals based on the beneficiary’s approved POC;
3. Implement the beneficiary’s therapy service plan in accordance with appropriate licensing and certification standards;
4. Complete progress notes for each session, within 10 days of the session, and provide notes to the beneficiary’s support coordinator every three months or as otherwise specified in the POC;
5. Maintain both current and past records and make them available upon request to OCDD, service providers, support coordinators, CMS, and/or legislative auditors, and
6. Bill only for services rendered, based on the beneficiary’s approved POC and PA.

Nursing Services Provider Responsibilities

Provider agencies of nursing services must:

1. Ensure that all nurses employed to provide nursing services are either registered nurses (RNs) or who have a current Louisiana Board of Nursing license or licensed practical nurses (LPNs) who have a current Louisiana State Board of Practical Nurse Examiners license, and have a minimum of one year of supervised nursing

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experience in providing skilled nursing services in a community setting to beneficiaries;

2. Provide an orientation on waiver services to licensed nurses and assure that licensed nurses adhere to the OCDD Critical Incident Reporting policy. (See Appendix D for information regarding this policy);
3. Collect and submit the following documents to the beneficiary's support coordination agency:
 - a. Primary care physician's (PCP's) order for nursing services;

NOTE: The physician's order must be signed and dated and must contain the number of hours per day and the duration of nursing services required to meet the beneficiary's needs. The physician's order must also be updated at least every 60 days, and a copy must be sent to the support coordination agency prior to expiration of the previous approval to ensure continuation of services. The physician's order must be submitted to the LGE with the beneficiary's annual POC and upon request. PA will not be released if the physician's order is not submitted as required.

- b. PCP's ***letter of necessity*** for nursing services. The physician's letter of necessity must be on the physician's letterhead, identify all nursing duties to be performed by the nurse, and state the beneficiary's current medical condition and need for nursing services;
 - c. Current ***Form 90-L*** signed by the beneficiary's PCP;
 - d. ***Summary*** of the beneficiary's medical history, which indicates the beneficiary's service needs based on a documented record review and specifies any recent (within one year) early and periodic screening, diagnosis, and treatment (EPSDT) extended home health approvals; and
 - e. ***CMS Form 485*** completed by the home health agency to identify the skilled nursing service needs.
 4. Develop and implement an individual nursing service plan in conjunction with the beneficiary's physician, support team, and the support coordinator to identify and fulfill the beneficiary's specific needs in a cost-effective manner;
 5. Render services to the beneficiary as ordered by the beneficiary's PCP and as reflected in the beneficiary's POC within the requirements of the Louisiana Nurse Practice Act. For the purpose of this policy, nursing assessments, nursing care planning, and revisions of care planning must be consistent with the Outcome and

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Assessment Information Set (OASIS) requirements used by home health agencies who provide skilled nursing services;

6. Complete progress notes for each treatment, assessment, intervention, and critical incident;
7. Provide the support coordination agency with physician-ordered changes every 60 days regarding the beneficiary's health status and health needs;
8. Inform the support coordinator immediately of the providers' inability to provide staff according to the beneficiary's nursing service plan;
9. Report any beneficiary's non-compliance with or refusal of the established individual nursing service plan and provide these notes to the designated support coordinator every 3 months, or as otherwise specified in the POC;
10. Maintain both current and past records and make them available upon request to the OCDD, service providers, support coordinators, CMS, and/or legislative auditors;
11. Bill for prior authorized services rendered based on the beneficiary's approved POC;
12. Ensure that the home health nurse and the beneficiary's support coordinator communicate at least monthly to determine if any further planning is required;
13. Report any changes in the beneficiary's nursing service needs to the support coordinator. If necessary, the support coordinator will call an Interdisciplinary Team meeting to review the POC and to discuss any needed revisions. Changes to skilled nursing services in accordance with regulations must be reflected in the individual nursing services plan and submitted to the support coordinator every 60 days;

NOTE: It is not necessary to revise the POC every 60 days unless there is a change in the beneficiary's medical condition requiring the need for additional skilled nursing services or the beneficiary requests a change.

14. Changes in the individual nursing service plan must be approved by the primary care physician and reflect the physician's orders for the skilled nursing service;
15. Ensure the individual nursing service plan is current and available in the beneficiary's home at all times;

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16. Follow all ROW requirements, LDH – HSS minimum standards for home health agencies, and State and Federal rules and regulations for licensed home health agencies and nursing care; and
17. Comply with OCDD standards for payment, Medical Assistance Program Integrity Law (MAPIL), Health Insurance Portability and Accountability Act (HIPAA), Americans with Disabilities Act (ADA), and licensing requirements.

Adult Day Health Care Providers

Services provided by an ADHC provider that:

1. Is licensed by the LDH HSS as an ADHC provider in accordance with Louisiana Revised Statutes 40:2120.47;
2. Has enrolled in Medicaid as an ADHC provider; and
3. Is listed on the OCDD FOC form.

NOTE: Qualifications for ADHC staff are set forth in the licensing regulations found in the Louisiana Administrative Code (LAC).

ADHC providers must:

1. Comply with all applicable LDH rules and regulations including the use of an approved EVV system; and
2. Provide transportation to any beneficiary within their licensed region in accordance with ADHC licensing standards.

NOTE: An ADHC center may serve a person residing outside of the ADHC center’s licensed region. However, transportation by the ADHC center is not required.

ADHC providers are not allowed to require that beneficiaries attend a minimum number of days per week. A beneficiary’s repeated failure to attend as specified in the POC may warrant a revision to the POC, or a possible discharge from the ADHC services and/or the ROW.

ADHC providers should notify the beneficiary’s support coordinator when a beneficiary routinely fails to attend the ADHC as specified.

When an ADHC provider reaches licensed capacity, the LGE should be notified immediately. The ADHC provider’s name will be removed from the OCDD FOC form until the ADHC provider

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notifies the LGE that they are able to admit new beneficiaries. (Refer to the ADHC Manual 9.5-Provider Requirements for additional information).

ADHC providers shall complete the LDH approved cost report and submit the cost report(s) to the LDH designated contractor on or before the last day of September following the close of the cost-reporting period.

Monitored In-Home Caregiving Service Providers

Services provided by a monitored in-home caregiving (MIHC) services provider that:

1. Has a HCBS provider license with MIHC;
2. Is approved by OCDD to provide MIHC services; and
3. Has enrolled in Medicaid to provide MIHC services.

MIHC providers must comply with LDH rules and regulations and be listed as a provider of choice on the OCDD FOC form as a MIHC services provider before being approved to provide services.

MIHC providers:

1. Must be agency providers who employ professional nursing staff and other professionals to train and support caregivers to perform the direct care activities performed in the home;
2. Must assess and approve the home in which services will be provided;
3. Shall enter into contractual agreements with caregivers whom they have approved and trained; and
4. Must pay per-diem stipends to caregivers.

STAFFING REQUIREMENTS

The Louisiana Department of Health (LDH) has the responsibility of establishing reasonable qualifications for providers to ensure that they are capable of providing services of acceptable quality to beneficiaries. The provider qualifications delineated in this section are dictated by the needs of the population to be served, and by the duties and responsibilities inherent in the provision of services as defined by LDH. LDH has established these staffing requirements to maintain an adequate level of quality, efficiency, and professionalism in the provision of all services in the Residential Options Waiver (ROW) program.

Community Living Supports

The following exclusions apply to community living supports (CLS) services:

1. Legally responsible individuals may only be paid for services when the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary;
2. In order to receive payment, relatives must meet the criteria for the provision of the service and the same provider qualifications specified for the service as other providers not related to the beneficiary; and
3. Relatives must also comply with the following requirements:
 - a. Become an employee of the beneficiary's agency of choice and meet the same standards as direct support staff who are not related to the individual; or
 - b. If the self-direction option is selected, relatives must:
 - i. Become an employee of the self-direction beneficiary; and
 - ii. Have a Medicaid provider agreement executed by the fiscal agent as authorized by the Medicaid agency.

NOTE: Authorized representatives may be the employer in the self-directed option but may not also be the employee.

1. Family members who may provide services include:
 - a. Parents of an adult child;

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- b. Siblings;
- c. Grandparents;
- d. Aunts, uncles; and
- e. Cousins.

NOTE: Anyone living in the same home and providing services will be capped at 40 hours per week per individual employed.

- 2. Services are not allowed to be provided in the non-related direct service worker's (DSW's) place of residence.

Host Home (Substitute Family Care)

Immediate family members, such as a beneficiary's mother, father, brother, sister, spouse, or curator, cannot be substitute family care parents.

Companion Care

Legally responsible individuals and legal guardians may provide Companion Care services for a beneficiary provided that the beneficiary requests the person as a roommate, living responsibilities and finances in the home are divided and shared with the provider agency, the care is provided in the beneficiary's residence and this service is in the best interest of the beneficiary

Companions must meet the DSW requirements as provided by LDH licensing standards, and the beneficiary and the companion must live in the same household.

Adult Day Health Care

Adult day health care services (ADHC) staffing requirements are identified in the ADHC licensing standards (LAC 48:I.4266, et seq.). Staff at the ADHC center shall meet the educational and experience requirements of job title and professional services.

Monitored In-Home Caregiving

Monitored in-home caregiving services (MIHC) staffing requirements are identified in the MIHC licensing standards (LAC 48:I.5101, et seq.). MIHC providers must be licensed home and community-based services (HCBS) providers with a MIHC module that employ professional staff,

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including a registered nurse (RN) and a care manager, to support principal caregivers in performing the direct care activities performed in the home. The principal caregiver shall be contracted by the licensed HCBS provider having a MIHC service module.

RECORD KEEPING

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the enrolled office site in the Louisiana Department of Health (LDH) administrative region where the beneficiary resides. The agency must have sufficient space, facilities, and supplies to ensure effective record keeping. The provider must keep sufficient records to document compliance with LDH requirements for the beneficiary served and the provision of services.

A separate record must be maintained on each beneficiary that fully documents services for which payments have been made. The provider must maintain sufficient documentation to enable LDH to verify that prior to payment each charge was due and proper. The provider must make available all records that LDH finds necessary to determine compliance with any federal or state law, rule, or regulation.

Confidentiality and Protection of Records

All records, including but not limited to, administrative and beneficiary files, must be secured against loss, tampering, destruction, or unauthorized use. Providers must comply with all state and federal laws and regulations concerning confidentiality and that safeguard information and patient/client confidentiality, including the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the beneficiaries, or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the beneficiaries or their families. The wrongful disclosure of such information may result in the imposition by LDH of sanctions pursuant to its Medicaid certification authority or the imposition of a monetary fine and/or imprisonment by the United States Government pursuant to the HIPAA Privacy Rule. The information may be released only under the following conditions:

1. Court order;
2. Beneficiary's written informed consent for release of information;
3. Written consent of the individual to whom the beneficiary's rights have devolved when the beneficiary has been declared legally incompetent; or
4. Written consent of the parent or legal guardian when the beneficiary is a minor.

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A provider must, upon request, make available information in the case records to the beneficiary or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the beneficiary, or reasonably likely to endanger the life or physical safety of the beneficiary, that information may be withheld. This determination must be documented in writing.

The provider may charge a reasonable fee for providing the above records. The cost of copying cannot exceed the community's competitive copying rate.

A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge or the provider's services, or similar educational purposes, if names are deleted and other similar protected health information is redacted or deleted.

A system must be maintained that provides for the control and location of all beneficiary records. Beneficiary records must be located at the enrolled site. **Under no circumstances should providers allow staff to take a beneficiary's case records from the facility.**

Review by State and Federal Agencies

Providers must make all administrative, personnel, and beneficiary records available to LDH and appropriate state and federal personnel at all reasonable times.

Retention of Records

The agency must retain administrative, personnel, and beneficiary records for whichever of the following time frames is longer:

1. 6 years from the date of the last payment period; or
2. Until records are audited and all audit questions are resolved.

NOTE: Upon agency closure, all provider records must be maintained according to applicable laws, regulations, and the above record retention requirements along with copies of the required documents transferred to the new agency. The new provider must bear the cost of copying, which cannot exceed the community's competitive copying rate.

Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements, LDH administrative rules and Medicaid enrollment agreements.

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Beneficiary Records

A provider must have a separate written record for each beneficiary served by the agency. It is the responsibility of the provider to have adequate documentation of services offered to waiver beneficiaries for the purposes of continuity of care, support for the individuals, and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of services received and undertaken on behalf of the beneficiary.

All beneficiary records and location of documents contained therein must be maintained consistently in the agency. Records must be appropriately maintained so that current material can be located in the record.

The Office of Citizens with Developmental Disabilities (OCDD) does not prescribe a specific format for documentation, but all components outlined must be in each beneficiary's active record.

Organization of Records, Record Entries, and Corrections

The organization of individual beneficiary records and the location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record.

All entries and forms completed by staff in beneficiary records must be legible, be written in ink, and include the following:

1. Name of the person making the entry;
2. Signature of the person making the entry;
3. Functional title of the person making the entry;
4. Full date of documentation; and
5. Supervisor review, if required.

Any error made by the staff in a beneficiary's record must be corrected using the legal method, which is to draw a line through the incorrect information, write "error" by it, and initial the correction. Correction fluid must never be used in a beneficiary's records.

Components of Beneficiary Records

The beneficiary record must consist of the active record and the agency's storage files or folders. The active record must contain, *at a minimum*, the following information:

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1. Identifying information on the beneficiary that is recorded on a standardized form to include the following:
 - a. Name;
 - b. Home address;
 - c. Home telephone number;
 - d. Date of birth (DOB);
 - e. Sex;
 - f. List of current medications;
 - g. Primary and secondary disability;
 - h. Name and phone number of preferred hospital;
 - i. Closest living relative;
 - j. Marital status;
 - k. Name and address of current employment, school, or day program, as appropriate;
 - l. Date of initial contact;
 - m. Court and/or legal status, including relevant legal documents, if applicable;
 - n. Names, addresses, and phone numbers of other beneficiaries or providers involved with the beneficiary's Plan of Care (POC), including the beneficiary's primary or attending physician;
 - o. Date when this information was gathered; and
 - p. Signature of the staff member gathering the information.
2. Documentation of the need for ongoing services;
3. Medicaid eligibility information;

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4. A copy of assurances of freedom of choice (FOC) of providers, beneficiary rights and responsibilities, confidentiality, and grievance procedures, etc. signed or initialed by the beneficiary;
5. Approved POC and provider documents, including any revisions,
6. Copy of all critical incident reports, if applicable;
7. Formal grievances filed by the beneficiary;
8. Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified in the Service Documentation below;
9. Attendance records;
10. Copy of the beneficiary’s behavior support plan, if applicable;
11. Documentation of all interventions (medical, consultative, environmental and adaptive) used to ensure the beneficiary’s health, safety, and welfare;
12. Reason for case closure and any agreements with the beneficiary at closure;
13. Copies of all pertinent correspondence;
14. At least 6 months (or all information if services provided less than 6 months) of current pertinent information relating to services provided;

NOTE: Records older than 6 months may be kept in storage files or folders, but must be available for review.

15. Any threatening medical condition, including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or any known allergies;
16. Monitoring reports of waiver service providers to ensure that the services outlined in the POC are delivered as specified;
17. Service logs describing all contacts, services delivered, and/or action taken and identifying the beneficiaries involved in service delivery, the date and place of service, the content of service delivery, and the services relation to the POC;

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18. A sign-out sheet that indicates the date and signature of the person(s) who viewed the record;
19. Any other pertinent documents; and
20. The provider must ensure that drivers have access to needed medical information including emergency contacts in the event of an emergency for all beneficiaries whom they transport.

If this information is kept as a hard copy record in the vehicle, it must be returned to a secure, location at the provider agency at the end of the transportation service.

Beneficiary’s transportation records must not be left in a vehicle.

Service Documentation

Support coordination agencies and direct service providers (DSPs) are responsible for documenting activities during the delivery of services. All documentation content and schedule requirements must be met by both support coordination agencies and DSPs.

Required service documentation includes:

1. Service logs;
2. Progress notes;
3. Project summaries;
4. Discharge summaries for transfers and closures; and
5. Individualized documentation.

NOTE: DSPs, who provide both waiver and state plan services, must maintain separate documentation for these services.

Service Logs

A service log provides a chronological listing of contacts and services provided to a beneficiary. They reflect the service delivered and document the services billed.

Federal requirements for documenting claims require the following information be entered on the service log to provide a clear audit trail:

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1. Name of beneficiary;
2. Name and signature of provider and employee providing the service;
3. Service agency contact and telephone number;
4. Date of service contact;
5. Start and stop time of service contact;

NOTE: The electronic visit verification (EVV) system will be used to document the start/stop time of service contact. If there is no electronic clock in/out, then paper documentation identifying the exact start and stop times with the date of the service contact is required, including the worker’s signature.

6. Place of service contact; and
7. Purpose of service contact:
 - a. Personal outcomes addressed;
 - b. Content and outcome of service contact; and
 - c. Other issues addressed.

There must be case record entries corresponding to each recorded support coordination and DSP activity that relates to one of the personal outcomes.

The service log entries need not be a narrative with every detail of the circumstances; however, all case notes must be clear as to who was contacted and what activity took place. Logs must be reviewed by the supervisor to insure that all activities are appropriate in terms of the nature and time and that documentation is sufficient.

Services billed must clearly be related to the current POC.

Each support coordination service contact is to be briefly defined (i.e., telephone call, face-to-face visit) with a narrative in the form of a progress note. This documentation should support justification of critical support coordination elements for prior authorization (PA) of service in the Data Management Contractor’s system.

DSPs must complete a narrative that reflects each entry into the payroll sheet and elaborates on the activity of the contact.

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Progress Notes

Progress notes must be completed by both support coordinators and DSPs at the time of each activity or service. Progress notes summarize the beneficiary's day-to-day activities and demonstrate progress toward achieving their personal outcomes as identified in the approved POC.

Progress notes must be of sufficient content to:

1. Reflect descriptions of activities, procedures, and incidents;
2. Give a picture of the service provided to the beneficiary;
3. Show progress towards the beneficiary's personal outcomes;
4. Record any change in the beneficiary's medical condition, behavior, or home situation that may indicate a need for reassessment and POC change;
5. Record any deviations from the typical weekly schedule in the beneficiary's approved POC; and
6. Reflect each entry in the service log and/or timesheet.

Checklists alone are not adequate documentation for progress notes.

The following are examples of general terms, when used alone, are not sufficient and do not reflect adequate content for progress notes:

1. "Supported _____";
2. "Assisted _____";
3. "_____ is doing fine";
4. "_____ had a good day"; and
5. "Prepared meals."

Progress notes must be reviewed by the supervisor to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

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For beneficiaries receiving formal training to learn a specific skill, progress notes must be paired with a skills training data sheet. The progress notes must document the skills training occurred and should serve as a pointer to data collection mechanisms used.

Progress Summary

A progress summary is a synthesis of all activities for a specified period that address significant activities, progress toward the beneficiary's desired personal outcomes, and changes in the beneficiary's social history. This summary must be of sufficient detail and analysis such that any person reviewing the record can determine if the progress is appropriate and satisfactory based on the beneficiary's current POC. The progress summary in the service log may be used by the support coordinators and DSPs to meet the documentation requirements.

A progress summary must be completed at least every quarter for each beneficiary.

Discharge Summary for Transfers and Closures

A discharge summary details the beneficiary's progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a beneficiary's discharge. The discharge summary in the service log may be used by the support coordinators and DSPs to meet the documentation requirement.

Individualized Documentation

The support team must ensure that other documentation and data collection methods other than progress notes and discharge summaries are considered so that appropriate measures are used to track the beneficiary's progress toward their goals and objectives as specified in the approved POC.

For persons with behavioral, psychiatric, or medical risk factors, individualized documentation should be utilized as a means of tracking each key area of risk. This documentation is required, but not limited to, beneficiaries with the following risk factors:

1. Seizure disorder and/or receiving seizure medication – Data forms used to track this information must include seizure reports. The support team may also need to consider assessing for the presence of side-effects of seizure medication on a monthly or quarterly basis;
2. A medical issue which is significantly affected by or has a significant effect upon one's weight – Such issues may include diabetes, cardiovascular issues, medication side-effects, or receiving nutrition via g-tube, peg-tube, etc. Data forms used to track this information must include weight logs. The support team may also need

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to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, and assessing for the presence of medication side-effects;

3. Medications which can have severe side effects or potentially cause death if the adherence to medication management protocols is not strictly followed - Data forms used to track this information must include an assessment for the presence of medication side-effects on a monthly or quarterly basis. The support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, and tracking frequency/consistency of bowel movements with a daily bowel log;
4. A psychiatric diagnosis and/or receiving psychotropic medication – Data forms used to track this information must include a psychiatric symptoms assessment. Based on the beneficiary’s presenting symptoms, antecedents, and psychotropic medication guidelines, the support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, tracking frequency/intensity of challenging behaviors with a challenging behavior chart, and assessing for the presence of medication side-effects; and
5. Challenging behaviors which are severe or disruptive enough to warrant a behavioral treatment plan – Data forms used to track this information must include behavioral incident reports. The support team may also need to consider tracking frequency/intensity of psychiatric symptoms with a psychiatric symptoms assessment, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, and assessing for the presence of medication side-effects.

The residential provider is responsible for collecting all required individualized documentation for the risk factors listed above and making it available to professionals, nursing, and medical personnel providing services to the beneficiary in order to facilitate quality of care. The data collection mechanism (e.g. the form or other collection method) related to these items must be submitted with the beneficiary’s POC and, if altered, with any succeeding revisions.

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Schedule of Required Documentation

SUPPORT COORDINATION AGENCIES AND DIRECT SERVICE PROVIDERS			
SERVICE LOG	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/TRANSFER
At time of activity	At time of activity	At least once every quarter.	Within 14 calendar days of discharge

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SECTION 38.9: REIMBURSEMENT**PAGE(S) 2**

REIMBURSEMENT

Providers of Residential Options Waiver (ROW) services must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. Refer to Appendix E for information about procedure code, unit of service and current reimbursement rates.

Up to three beneficiaries may choose to share Community Living Support (CLS) services if they share a common provider of this service. CLS services may share a direct support worker (DSW) across three waivers: the Children’s Choice (CC) Waiver (Family Supports) and/or New Opportunities Waiver (NOW) (individual and family supports). However, sharing a DSW at the same time across all three waivers is not allowed.

The claim submission date cannot precede the date the service was rendered.

All claims for ROW services shall be filed by electronic claims submission 837P or on the CMS-1500 claim form.

Electronic Visit Verification

An electronic visit verification (EVV) system has been implemented for some ROW services. The following services are required to be electronically clocked in/out of the Louisiana Service Reporting System (LaSRS®). Providers who have an existing EVV program that has been approved by the Office of Citizens with Developmental Disabilities (OCDD) and Bureau of Health Services Financing (BHSF) will be exempted from using the LaSRS® for these services.

Providers who fail to use an approved EVV system for services may be subject to payment hold and/or denial of reimbursement.

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Services in LaSRS® for Electronic Clock In/Out
Day Habilitation Services (all services)
Prevocational Services (all services)
Supported Employment (all services)
Respite Care Services- Out of Home
Transportation for Day Habilitation, Prevocational and Supported Employment
CLS (all services)
Professional Services - Physical Therapy
Nursing Services
Adult Day Health Care (ADHC) Center Based Services
Support Coordination
Community Life Engagement Development

EVV options are:

1. Mobile Application accessed on a cell phone or tablet with internet connectivity;
2. Landline telephone in the home of the beneficiary; or
3. FOB security device is kept in home at all times used to verify clock in/clock out times.

The EVV Connectivity Form may be used in area with limited or no internet/cell phone connectivity. **The ONLY legitimate reason to complete a connectivity form is for poor or no internet/cell phone services where service delivery occurs.**

Direct Support Worker Wage Floor for Medicaid HCBS for Intellectual and Developmental Disabilities

Medicaid has established a DSW Wage floor. Provider agencies must follow these rules and pay the DSW as directed by Medicaid. The current wage floor can be found in the Louisiana Administrative Code and the OCDD on the OCDD website. Providers will be responsible for following this directive.

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PROGRAM MONITORING

Services offered through the Residential Options Waiver (ROW) program are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal regulations. Medicaid's Health Standards Section (HSS) staff or its designee conducts on-site reviews of the home and community based waiver (HCBS) provider agencies. These reviews are conducted to monitor the provider agency's compliance with Medicaid's provider enrollment participation requirements, continued capacity for service delivery, quality and appropriateness of service provision to the waiver group, and the presence of the personal outcomes defined and prioritized by the individuals served.

The HSS reviews include a review of administrative records, personnel records, and a sample of beneficiary records. In addition, provider agencies are monitored with respect to the following:

1. Beneficiary's access to needed services identified in the service plan;
2. Quality of assessment and service planning;
3. Appropriateness of services provided including content, intensity, frequency and beneficiary input and satisfaction;
4. The presence of the personal outcomes as defined and prioritized by the beneficiary and/or responsible representative; and
5. Internal quality improvement.

A provider's failure to follow State licensing standards and Medicaid policies and practices could result in the provider's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

On-Site Reviews

On-site reviews with the provider agency are unannounced and conducted by HSS staff to:

1. Ensure compliance with program requirements; and
2. Ensure that services provided are appropriate to meet the needs of the beneficiaries served.

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Administrative Review

The Administrative Review includes the following:

1. A review of administrative records;
2. A review of other provider agency documentation; and
3. Provider agency staff interviews, as well as interviews with a sampling of beneficiaries, to determine continued compliance with provider participation requirements.

Failure to respond promptly and appropriately to the HSS monitoring questions or findings may result in sanctions, liquidated damages, and/or recoupment of payment.

Interviews

As part of the on-site review, the HSS staff will interview:

1. A representative sample of the individuals served by each provider agency employee;
2. Members of the beneficiary's circle or network of support, which may include family and friends;
3. Service providers; and
4. Other members of the beneficiary's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency, and direct service providers (DSPs) and other employees of the DSP agency.

This interview process is to assess the overall satisfaction of beneficiaries regarding the provider agency's performance, and to determine the presence of the personal outcomes defined and prioritized by the beneficiary/guardian.

Personnel Record Review

The Personnel Record Review includes the following:

1. A review of personnel files;

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2. A review of electric visit verification (EVV) record/time sheets; and
3. A review of the current organizational chart.

Beneficiary Record Review

A representative sample of beneficiary records are reviewed to ensure the services and supports delivered to beneficiaries are rendered according to the beneficiary's approved plan of care (POC). The case record must indicate how these activities are designed to lead to the desired personal outcomes, or how these activities are associated with organizational processes leading to the desired personal outcomes of the beneficiaries served.

Beneficiary records are reviewed to ensure that the activities of the provider agency are correlated with the appropriate services of intake, ongoing assessment, planning (development of the POC), transition/closure, and that these activities are effective in assisting the beneficiary to attain or maintain the desired personal outcomes.

Documentation is reviewed to ensure that the services reimbursed were:

1. Identified in the POC;
2. Provided;
3. Documented properly;
4. Appropriate in terms of frequency and intensity; and
5. Relate back to personal outcomes on the POC.

Provider Staff Interviews

Provider agency staff is interviewed as part of the on-site review to ensure that staff meets the following qualifications:

1. Education;
2. Experience;
3. Skills;
4. Knowledge;

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5. Employment status;
6. Hours worked;
7. Staff coverage;
8. Supervisor to staff ratio;
9. Caseload/beneficiary assignments;
10. Supervision documentation; and
11. Other applicable requirements.

Monitoring Report

Upon completion of the on-site review, the HSS staff discusses the preliminary findings of the review in an exit interview with appropriate provider staff. The HSS staff compiles and analyzes all data collected in the review, and a written report summarizing the monitoring findings and recommended corrective action is sent to the provider agency.

The monitoring report includes the following:

1. Identifying information;
2. A statement of compliance with all applicable regulations; or
3. Deficiencies requiring corrective action by the provider.

The HSS program managers will review the reports and assess any sanctions as appropriate.

Corrective Action Report

The provider is required to submit a plan of correction to HSS within **10 working days of receipt of the report**.

The plan must address *how each cited deficiency has been corrected and how recurrences will be prevented*. The provider is afforded an opportunity to discuss or challenge the HSS monitoring findings.

Upon receipt of the written plan of correction, HSS program managers review the provider's plan to assure that all findings of deficiency have been adequately addressed. If all deficiencies have

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not been addressed, the HSS program manager responds to the provider requesting immediate resolution of those deficiencies in question.

A follow-up monitoring survey will be conducted when deficiencies have been found to ensure that the provider has fully implemented the plan of correction. Follow up surveys may be conducted on-site or via evidence review.

Informal Dispute Resolution (Optional)

In the course of monitoring duties, an informal hearing process may be requested. The provider is notified of the right to an informal hearing in correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits the right of the provider to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix C for contact information).

This request must be made within the time limit given for the corrective action recommended by the HSS.

The provider is notified of the time and place of the informal hearing. The provider should bring all supporting documentation that is to be submitted for consideration. Every effort will be made to schedule a hearing at the convenience of the provider.

The HSS program manager convenes the informal hearing and providers are given the opportunity to present their case and to explain their disagreement with the monitoring findings. The provider representatives are advised of the date to expect a written response and are reminded of their right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the Louisiana Department of Health (LDH) Bureau of Appeals.

Fraud and Abuse

When HSS staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Program Integrity Section of the Medicaid program for investigation and sanctions, if necessary. Investigations and sanctions may also be initiated from reviews conducted by the Surveillance and Utilization Review System (SURS) of the Medicaid program. LDH has an agreement with the Office of the Attorney General to investigate Medicaid fraud. The Office of the Inspector General (OIG), Federal Bureau of Investigation (FBI), and postal inspectors also conduct investigations of Medicaid fraud.

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Quality Management

DSPs and support coordination agencies must have a quality enhancement process that involves the following:

1. Learning;
2. Responding;
3. Implementing; and
4. Evaluating.

Agency quality enhancement activities must be reviewed and approved by the local governing entity (LGE) as described in the *Quality Enhancement Provider Handbook*. (See Appendix D for information on this handbook).

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SECTION 38.11: INCIDENTS, ACCIDENTS AND COMPLAINTS

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INCIDENTS, ACCIDENTS AND COMPLAINTS

The support coordination agency and direct service provider (DSP) are responsible for ensuring the health and safety of the beneficiary. Support coordination and direct service staff must report all incidents, accidents, or suspected cases of abuse, neglect, exploitation, or extortion to the on-duty supervisor immediately and as mandated by law to the appropriate agency. Reporting an incident only to a supervisor does not satisfy the legal requirement to report. The supervisor is responsible for ensuring that a report or referral is made to the appropriate agency.

All suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation, or extortion must be reported to the appropriate authorities. (Refer to Appendix C for contact information).

If the beneficiary needs emergency assistance, the worker shall call 911 or the local law enforcement agency.

Any other circumstances that place the beneficiary's health and well-being at risk should also be reported.

Support coordination agencies and DSPs are responsible for documenting and maintaining records of **all** incidents and accidents involving the beneficiary. The Office for Citizens with Developmental Disabilities' (OCDD) *Critical Incident Reporting, Tracking and Follow-up Activities for Waiver Services* procedures must be followed for all reporting, tracking, and follow-up activities of all critical incidents. Non-compliance shall result in administrative actions as indicated in this document. (See Appendix D for information on where to obtain a copy of this document).

Note: It is the policy of the Louisiana Department of Health (LDH), OCDD that all critical incidents for home and community-based services (HCBS) be reported, investigated and tracked. The statewide incident management system **MUST** be used for **ALL** critical incident reporting.

Internal Complaint Policy

Beneficiaries must be able to file a complaint regarding their services without fear of reprisal. The provider shall have a written policy to handle beneficiary complaints. In order to ensure that the complaints are efficiently handled, the provider shall comply with the following procedures:

1. Each provider shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint, and resolution of the complaint;

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2. If the complaint is verbal, the provider staff member receiving the complaint must obtain and send all pertinent information in writing to the provider complaint coordinator. If the beneficiary completes the complaint form, they will be responsible for sending the form to the provider complaint coordinator;
3. The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint **within 5 working days**;
4. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the beneficiary, the personal representative, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution;
5. The provider's administrator or designee must inform the beneficiary and/or the personal representative in writing **within 10 working days** of receipt of the complaint, the results of the internal investigation; and
6. If the beneficiary is dissatisfied with the results of the internal investigation regarding the complaint, they may continue the complaint resolution process by contacting the appropriate local governing entity (LGE) in writing, or by telephone.

If the complainant's name and address are known, the LGE will notify the complainant **within 2 working days** that the complaint has been received and action on the complaint is being taken.

Complaint Disclosure Statement

Louisiana R.S. 40:2009.13 – 40:2009.21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the HCBS waiver programs. When the substance of the complaint is furnished to the service provider, it shall not identify the complainant or the beneficiary unless they consent in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

The OCDD may determine when the complaint is initiated that a disclosure statement is necessary. If a Complainant Disclosure Statement is necessary, the complainant must be contacted and given an opportunity to withdraw the complaint.

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If the complainant still elects to file the complaint, the OCDD will mail or FAX the disclosure form to the complainant with instructions to return it to the OCDD State Office.

Definition of Related Terms Regarding Incidents and Complaints

The following definitions are used in the incident and complaint process:

1. **Complaint** - an allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a beneficiary (La. R.S. 40:2009.14);
2. **Minimal harm** - is an incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the beneficiary's activities of daily living (ADL). (La. R.S. 40:2009.14);
3. **Trivial report** - is a report of an allegation that an incident has occurred to a beneficiary or that causes no physical or emotional harm and has no potential for causing harm to the beneficiary. (La. R.S. 40:2009.14);
4. **Allegation of noncompliance** - is an allegation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a beneficiary. (La. R.S. 40:2009.14);
5. **Abuse** - is the infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered. (La. R.S. 15:1503);
6. **Exploitation** - is the illegal or improper use or management of an aged person's or disabled adult's funds, assets, or property, or the use of an aged person's or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 15:1503);
7. **Extortion** - is the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503);
8. **Neglect** - is the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in

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accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503);

9. **Self-neglect** - is the failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503);

10. **Sexual abuse** - is any sexual activity between a beneficiary and staff without regard to consent or injury; any non-consensual sexual activity between a beneficiary and another person; or any sexual activity between a beneficiary and another beneficiary or any other person when the beneficiary lacks the capacity to give consent. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; request, suggestion, or encouragement by another person for the beneficiary to perform sex with any other person when beneficiary is not competent to refuse;

11. **Disabled person** - is a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for their own care or protection; and

12. **Incident** - any situation involving a beneficiary that is classified in one of the categories listed in this section, or any category of event or occurrence defined by OCDD as a critical event, and has the potential to impact the beneficiary or affect delivery of waiver services.

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SUPPORT COORDINATION

Support coordination, which is also referred to as case management, is a waiver service that is provided to all Louisiana Residential Options Waiver (ROW) beneficiaries. Support coordination is an organized system by which a support coordinator assists a beneficiary to prioritize and define their personal outcomes and to identify, access, coordinate and monitor appropriate supports and services within a community service network. Beneficiaries may have multiple service needs and require a variety of community resources.

Core Elements

Support coordination agencies are required to perform the following:

1. Intake;
2. Assessment;
3. Plan of Care (POC) Development and Implementation;
4. Follow-Up/Monitoring;
5. Reassessment; and
6. Transition/Closure.

Intake

The local governing entity (LGE) serves as an entry point for Louisiana Medicaid Waiver services. When criteria are met, individual's names are placed on the registry. All waiver participants choose their Support Coordination and Direct Services Provider Agencies through the Freedom of Choice (FOC) Process. As part of the Tired Waiver Process guidelines, the Office for Citizens with Developmental Disabilities (OCDD) will offer the most appropriate waiver based on person-centered planning and a needs-based assessment. All children under age 22 enter the waiver system into the Children's Choice (CC) Waiver and all adults enter with current unmet needs into the Supports Waiver (SW). If an individual's needs cannot be met with the initial waiver they may request moving up to the next waiver in the Tiers. The ROW is the second Tier within the OCDD Tiered Waiver process.

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Intake Procedures

Referrals for support coordination services are only made from OCDD through the Medicaid data contractor. The applicant must be interviewed to obtain the required demographic information, preferably face-to-face in the applicant's home, within 3 working days of receipt of the FOC form.

The POC process begins with an initial face-to-face meeting in the beneficiary's home. The support coordinator requests and gathers medical, social, educational and psychological documentation necessary to complete the POC. The LGE will transfer eligibility documents with the transfer of records to the support coordination agency. Prior authorization (PA) to cover services from the beginning date of the POC will be issued upon approval of the POC.

The support coordinator must determine whether the applicant:

1. Has a need for immediate support coordination intervention; and
2. Is receiving support coordination service or other services from another provider or community resource.

NOTE: If the applicant is receiving support coordination from another OCDD provider, the OCDD State Office Support Coordination Program Manager must be contacted to correct the linkage. (See Appendix C for contact information).

Applicants who are receiving support coordination from another provider must remain with their current provider until approved for the waiver. Requests to change to a different support coordination agency may be made following waiver certification. Refer to "Changing Support Coordination Agencies" at the end of this section.

The support coordinator must obtain signed release forms and have the applicant/authorized representative sign a standardized intake form that documents the applicant/ authorized representative:

1. Was informed of procedural safeguards;
2. Was informed of their rights along with grievance procedures;
3. Was advised of their responsibilities;
4. Accepted support coordination service;

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5. Was advised of the right to change support coordination providers, support coordinators, service providers; and
6. Was advised that waiver services and support coordination service are an alternative to institutionalization.

If the services in the waiver are not appropriate to meet the applicant's needs, or if the applicant does not meet the eligibility requirements for waiver services, the applicant should be notified immediately, given appeal rights and directed to other service options or to the source of the initial referral.

Assessment

Assessment is the process of gathering and integrating informal and formal/professional information relevant to the development of an individualized POC. The information should be based on, and responsive to, the beneficiary's current service needs, desired personal outcomes and functional status. The assessment provides the foundation for support coordination service by defining the beneficiary's needs and assisting in the development of the POC.

Assessment Process

The person-centered support assessment must be conducted by the support coordinator and consist of the following:

1. Face-to-face home interviews with the beneficiary/beneficiary's family or guardian/authorized representative;
2. Direct observation of the beneficiary;
3. Direct contact with family, other natural supports, professionals and support/service providers as indicated by the situation and the desires of the beneficiary; and
4. FOC of all services, support coordination and alternative to institutionalization.

Characteristics and components of the assessment include:

1. Identifying information (demographics);
2. The use of a standardized instrument for certain targeted populations;

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3. Personal outcomes identified, defined and prioritized by the beneficiary;
4. Medical/physical information;
5. Psycho social/behavioral information;
6. Developmental/intellectual information;
7. Socialization/recreational information including the social environment and relationships that are important to the beneficiary;
8. Patterns of the beneficiary's everyday life;
9. Financial resources;
10. Educational/day habilitation and/or employment information;
11. Housing/physical environment of the beneficiary;
12. Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes;
13. Information relevant to understanding the supports and services needed by the beneficiary to achieve the desired personal outcomes, (e.g., input from formal and informal service providers and caregivers as relevant to the personal outcomes); and
14. Identification of areas where a professional evaluation is necessary to determine appropriate services or interventions.

It is the responsibility of the support coordinator to assist the beneficiary to arrange any professional/clinical evaluations that are needed to develop strategies for obtaining the services, resources and supports necessary to achieve their desired personal outcomes while ensuring beneficiary choice. The support coordinator must identify, gather and review the array of formal assessments and other documents that are relevant to the beneficiary's needs, interests, strengths, preferences and desired personal outcomes. A signed authorization must be obtained from the beneficiary or guardian (if the beneficiary is a minor) or authorized representative to secure appropriate services. A signed authorization for release of information must be obtained and filed in the case record.

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NOTE: Evaluations, tests, or reports are not covered support coordination activities. The necessary medical, psychological, psycho social and/or other clinical evaluations, tests, etc. may be covered by Medicaid or other funding sources.

Time Frame for Initial Assessment

The initial assessment must begin **within 7 calendar days** and be completed **within 30 calendar days** following the referral/linkage.

Ongoing Assessment Procedures

The assessment must be ongoing to reflect changes in the beneficiary's life and the changing prioritized personal outcomes over time. These changes include strengths, needs, preferences, abilities and the resources of the beneficiary. If there are significant changes in the beneficiary's status or needs, the support coordinator must revise the POC.

Plan of Care Development and Implementation

The POC is the analysis of information from the formal evaluations and the person-centered supports assessment and is based on the unique personal outcomes identified, defined and prioritized by the beneficiary.

The POC is developed through a collaborative process involving the beneficiary and the persons who the beneficiary chooses to participate in the process that may include, family, friends or other support systems, the support coordinator and appropriate professionals/service providers and others who know the beneficiary best.

The POC serves to:

1. Establish direction for all persons involved in providing supports and services for the beneficiary by describing how the needed supports and services interact to form overall strategies that assist the beneficiary to maintain or achieve the desired personal outcomes of their choice;
2. Provide a process for ensuring that the paid medical services and other resources are deemed medically necessary and meet the needs and desires of the beneficiary including health and welfare as determined by the assessment, and that these services and supports are provided in a cost-effective manner; and

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3. Represent a strategy for ensuring that services are the choice of the beneficiary, appropriate, available, and responsive to the beneficiary's changing outcomes and desires needs as updated in the assessment.

The POC should not be considered a treatment plan of specific clinical interventions that service providers would use to achieve treatment or rehabilitation goals. Instead, the POC should be considered a "master plan" consisting of a comprehensive summary of information to aid the beneficiary to obtain assistance from formal and informal service providers as it relates to obtaining and maintaining the desired personal outcomes of the beneficiary.

Required Procedures

The initial and annual POC must be completed in a face-to-face home visit with the beneficiary, service provider and members of the support network, which may include family members, appropriate professionals, and others, who are well acquainted with the beneficiary and who the beneficiary chooses to invite. The POC must be held at a time that is convenient for the beneficiary.

The POC must be outcome-oriented, individualized and updated at least annually. The planning process should include tailoring the POC to the beneficiary's needs and desires based on the ongoing personal outcomes assessment. It must develop mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports and appropriate formal paid services. The beneficiary, support coordinator, members of the support system, direct service providers (DSPs), and appropriate professional personnel must be directly involved in the development of the POC.

The POC must assist the beneficiary to make informed choices including the choice to receive services in a non-disability specific setting, and about all aspects of supports and services needed to achieve their desired personal outcomes which involves assisting the beneficiary to identify specific, realistic needs and choices for the POC. It must also assist the beneficiary in developing an action plan which will lead to the implementation of strategies to achieve the desired personal outcomes, including action steps, review dates and individuals who will be responsible for specific steps.

The POC must incorporate steps that empower and help the beneficiary to develop independence, growth, and self-management.

The POC must be written in language that is understandable to all parties involved. Specific problems due to a diagnosis or situation that causes a problem for the beneficiary must be clearly explained. The POC must be approved prior to issuance of any PA.

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Required Components

The POC must incorporate the following required components and shall be prepared by the support coordinator with the chosen service provider, beneficiary, parent/family and others, at the request of the beneficiary:

1. The beneficiary's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal natural/community supports and if needed, paid formal services;
2. Budget payment mechanism, as applicable;
3. Target/resolution dates for the achievement/maintenance of personal outcome;
4. Assigned responsibilities;
5. Identified preferred formal and informal support/service providers and the specific service arrangements;
6. Identified individuals who will assist the support coordinator in planning, building/implementing supports, or direct services;
7. Ensured flexibility of frequency, intensity, location, time and method of each service or intervention and is consistent with the POC and beneficiary's desired outcomes;
8. Change in a waiver service provider(s) can only be requested by the beneficiary at the end of a 6 months linkage unless there is "good cause." Any request for a change requires a completion of a FOC form. A change in support coordination providers is to be made through the Medicaid data contractor. A change in DSPs is to be made through the support coordinator;
9. All participants present at the POC meeting must sign the POC;
10. The POC must be completed and approved as per POC instructions; and
11. The beneficiary must be informed of their right to refuse a POC after carefully reviewing it.

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Building and Implementing Supports

The implementation of the POC involves arranging for, building, and implementing a continuum of both informal supports and formal/professional services that will contribute to the achievement of the beneficiary's desired personal outcomes.

Responsibilities of the support coordinator include:

1. Building and implementing the supports and services as described in the POC;
2. Assisting the beneficiary/family to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the beneficiary in the POC;
3. Being aware of and providing information to the beneficiary/family on potential community resources, including formal resources (Supplemental Nutrition Assistance Program (SNAP) Benefits, Supplemental Security Income (SSI), housing, Medicaid, Benefits Planning, etc.) and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining their desired personal outcomes;
4. Assisting with problem solving with the beneficiary, supports, and services providers;
5. Assisting the beneficiary to initiate, develop, and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet the beneficiary's individual needs and desires;
6. Advocating on behalf of the beneficiary to assist in obtaining benefits, supports, or services, e.g., to help establish, expand, maintain and strengthen the beneficiary's informal and natural support networks by calling and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;
7. Training, supporting and/or connecting the beneficiary in self-advocacy groups, e.g., selection of providers and utilization of community resources to achieve and maintain the desired outcomes;
8. Overseeing the service providers to ensure that the beneficiary receives appropriate services and outcomes as designed in the POC;

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- 9. Assisting the beneficiary to overcome obstacles, recognize potential opportunities, and develop creative opportunities;
- 10. Monthly phone calls with the beneficiary, and
- 11. Meeting with the beneficiary face-to-face in the beneficiary’s home for each initial and/or annual POC development, and at least one other quarterly meeting or more often if requested by the beneficiary/family. If the beneficiary meets the criteria for virtual visits, the remaining 2 quarterly meetings may be completed using a virtual delivery format.

NOTE: Advocacy is defined as assuring that the beneficiary receives appropriate supports and services of high quality and locating additional services not readily available in the community.

Required Time Frames

- 1. Linkage;
 - a. The initial POC must be completed and received by the LGE within 35 calendar days following the date of the notification of linkage by the data contractor. All incomplete packages will be returned;
 - b. Revisions to the POC; and
 - c. Routine changes, such as vacations or when school is not in session, must be submitted 7 working days prior to the change.
- 2. Emergencies;
 - a. Emergency changes must be submitted within 24 hours or the next working day following the change.
- 3. Reviews;
 - a. The POC must be reviewed after implementation to ensure that the personal outcomes and support strategies are consistent with the needs and desires of the beneficiary; and
 - b. The POC must be revised annually (and as required) and submitted to the LGE no later than 35 days prior to expiration. The POC may be submitted

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as early as 60 days prior to expiration provided the form 90-L does not expire prior to the POC expiration date.

Changes in the Plan of Care

If there are significant changes (adding or deleting services) in the way the beneficiary prioritizes their personal outcomes, and/or if there are significant changes in the support strategies or service providers, the support coordinator must revise the POC to reflect these changes. A revision request must be submitted to the LGE for approval on all beneficiaries.

There is flexibility in the POC for the family to use the services as needed as long as the reimbursement from Medicaid remains within the waiver cap. Therefore, changes will occur only when a service is added or removed from the POC.

Initiating a Change in the Plan of Care

The beneficiary/family will contact the support coordinator when a change is required. The support coordinator will call a meeting with the service provider to complete the POC revision form. All participants will sign the POC revision, and it will be submitted to the LGE for approval. The support coordinator will notify the service provider and beneficiary of the approval/disapproval.

NOTE: The annual expiration date of the POC should never change.

Documentation

The POC must include the frequency and location of the support coordinators' face-to-face contacts with the beneficiary.

A copy of the approved POC must be kept at the beneficiary's home, in the beneficiary's case record at the support coordination agency, and in the service provider's files. The support coordinator is responsible for providing the copies.

A copy of the POC must be made available to all staff directly involved with the beneficiary.

Follow-Up/Monitoring

Follow-up/monitoring is the mechanism used by the support coordinator to assure the appropriateness of the POC. Through follow-up/monitoring activity, the support coordinator not only determines the effectiveness of the POC in meeting the beneficiary's needs, but identifies when changes in the beneficiary's status necessitate a revision in the POC. The purpose of the follow-up/monitoring contacts is to determine:

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1. If services are being delivered as planned;
2. If services are effective and adequate to meet the beneficiary's needs; and
3. Whether the beneficiary is satisfied with the services.

The support coordinator and the beneficiary develop an action plan to monitor and evaluate strategies to ensure continued progress toward the beneficiary's personal outcomes.

Every calendar month after linkage, the support coordinator must make phone contact with the beneficiary to address the following:

1. Does the beneficiary/family feel the outcomes are being met;
2. Are the times the services are being provided convenient and satisfactory to the beneficiary/family;
3. Does the beneficiary/family have any problems or changes that may require additional services;
4. Are the providers actually present at the times indicated; and
5. Are the provided services adequate and of good quality.

The beneficiary/family should be informed of the necessity to contact the support coordinator when there are significant changes in beneficiary's status or if problems arise with service providers. A major change in status requires a reassessment. If the change is determined to be a long-term situation, refer to Crisis Provisions.

Notify service providers within 3 working days of written changes in the POC.

Meet with the beneficiary between the sixth and ninth month of implementation of the POC to determine the effectiveness of the support strategies and, if necessary, to revise the POC.

All visits and contacts should be documented in the case record using monthly progress notes. Progress notes may be brief as long as all components are addressed. Information documented in the progress notes does not need to be duplicated in the case record.

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Monthly progress notes must address personal outcomes separately and reflect the beneficiary's interpretation of the outcomes. Monthly progress notes shall include:

1. Desired personal outcomes;
2. Strategies to achieve the outcomes;
3. Effectiveness of the strategies;
4. Obstacles to achieving the desired outcomes;
5. New opportunities; and
6. Developing a new action plan.

Reassessment

Assessment must be ongoing to reflect changes in the beneficiary's life and the changing prioritized personal outcomes over time such as strengths, needs, preferences, abilities and the beneficiary's resources. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the overall POC.

A reassessment is required when a major change occurs in the status of the beneficiary, the beneficiary's family, or the beneficiary's prioritized needs. A reassessment must be completed **within 7 calendar days** of notice of a change in the beneficiary's status.

NOTE: The beneficiary/family may request a complete POC review by the LGE at any time during the POC year if it is felt the POC is unsatisfactory or is inadequate in meeting the beneficiary's service needs.

Annual Reassessment

A completed annual reassessment package must be received by the LGE no later than **35 calendar days**, but as early as **90 calendar days** prior to expiration of the POC, provided the form 90-L does not expire prior to the POC expiration date. Incomplete packages will not be accepted. Support coordinators will be responsible for retrieving incomplete packages from the LGE. Sanctions will be applied.

Support coordinators have limited POC approval authority as authorized by OCDD policy and procedure. Approval of a POC for an annual reassessment shall be limited to those cases where:

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1. The beneficiary’s health and welfare can be assured;
2. There are no changes in waiver services; and
3. The current waiver services are meeting the needs of the beneficiary.

NOTE: All necessary documentation must be submitted to the LGE with a copy of the approved POC.

Support coordinators **do not** have authority to approve a POC when any of the following occurred during the previous POC year:

1. Skilled nursing care;
2. Direct service worker (DSW) given delegation for medication administration or delegation for a complex or non-complex task;
3. There were 3 or more critical incident reports during the POC year; or
4. There was any report with a substantiated investigation to the Department of Children and Family Services’ (DCFS) Child Welfare Division or the Louisiana Department of Health’s (LDH’s) Adult Protective Services.

Transition/Closure

The transition or closure of support coordination services must occur in response to the request of the beneficiary, or if the beneficiary is no longer eligible for services. The closure process must ease the transition to other services or care systems.

Closure Criteria

Criteria for closure of waiver and support coordination services include, but are not limited to, the following:

1. The beneficiary requests termination of services;
2. Death;
3. Permanent relocation of the beneficiary out of the service area (transfer to another region) or out of state;

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4. Long term admission to an institution or nursing facility;
5. The beneficiary requires a level of care (LOC) beyond that which can safely be provided through waiver services; or
6. Beneficiary refuses to comply with support coordination.

Procedures for Transition/Closure

The support coordinator must provide assistance to the beneficiary and to the receiving agency during a transition to assure the smoothest possible transition. Transition/closure decisions should be reached with the full participation of the beneficiary/family. Support coordinators must:

1. Notify the beneficiary/family immediately if the beneficiary becomes ineligible for services;
2. Complete a final written reassessment identifying any unresolved problems or needs and discuss with the beneficiary methods of negotiating their own service needs;
3. Notify the service provider immediately if services are being transitioned or closed; and
4. Assure the receiving agency, program or support coordinator receives copies of the most current POC and related documents. (The form 148-W must be completed to reflect the date on the transfer of records and submitted to the LGE).

The support coordination agency must:

1. Notify the LGE of the transition/closure 4 weeks prior to the closure to allow the LGEs to establish a transition plan;
2. Follow their own policies and procedures regarding intake and closure; and
3. Serve as a resource to beneficiaries who choose to assume responsibility for coordinating some or all of their own services and supports, or who choose to ask a member of their network of support to assume some or all of these responsibilities. All closures must be entered into the database immediately.

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NOTE: An agency shall not close a beneficiary's case that is in the process of an appeal. Only upon receipt of the appeal decision may the case be closed. If an appeal is requested within 10 days, the case remains open. If not requested within 10 days, the case will be closed.

The agency shall not retaliate in any way against the beneficiary for terminating services or transferring to another agency for support coordination services.

Changing Support Coordination Agencies

When a beneficiary selects a new support coordination provider, the data contractor will link the beneficiary to the new provider. The new support coordination provider must:

1. Complete the FOC file transfer;
2. Obtain the case record and authorized signature; and
3. Inform the transferring support coordination agency.

Upon receipt of the completed form, the transferring provider must provide copies of the following information:

1. Most current POC;
2. Current assessments on which the POC is based;
3. Number of services used in the calendar year;
4. Most recent 6 months of progress notes; and
5. Form 90-L.

The transferring support coordination provider shall provide services up to the transfer of the records and is eligible to bill for support coordination services after the dated notification is received (transfer of records) by the receiving agency. In the month the transfer occurs, the receiving agency shall begin services within 3 days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. The receiving agency must submit the required documentation to the LGE/Medicaid contractor to begin PA immediately after the transfer of records.

Other Support Coordination Responsibilities

Assistance with Self-Direction Option

Support coordinators are responsible for providing assistance to beneficiaries who select to participate in the self-direction option with the following activities:

1. Training beneficiaries on their responsibilities as an employer;
2. Completing required forms for participation in the self-direction option;
3. Assisting with development of back-up service plan;
4. Assisting with development of budget planning;
5. Verifying potential employees meet program qualifications;
6. Ensuring the beneficiary's needs are being met through services; and
7. Monitoring the beneficiary's self-directed services face-to-face each quarter.

Reporting of Incidents, Accidents and Complaints

The support coordinator must report and document any complaint, incident, accident, suspected case of abuse, neglect, exploitation or extortion to the OCDD, Health Standards Section (HSS), and other appropriate agency as mandated by law. All suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion must be reported to the appropriate authorities. Refer to Section 38.11 – Incidents, Accidents and Complaints for additional instructions.

DEVELOPMENTAL DISABILITY LAW

A developmental disability is defined by the Developmental Disability Law (Louisiana Revised Statutes 28:451.1-28:455.2). The law states that a developmental disability means either:

1. A severe chronic disability of a person that:
 - a. Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments;
 - b. Is manifested before the person reaches age twenty-two;
 - c. Is likely to continue indefinitely;
 - d. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
 - i. Self-care;
 - ii. Receptive and expressive language;
 - iii. Learning;
 - iv. Mobility;
 - v. Self-direction;
 - vi. Capacity for independent living; and
 - vii. Economic self-sufficiency.
 - e. Is not attributed solely to mental illness; and
 - f. Reflects the person’s need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

OR

2. A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high

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APPENDIX A: DEVELOPMENTAL DISABILITY LAW

probability of resulting in those criteria listed above later in life that may be considered to be a developmental disability.

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GLOSSARY

The following is a list of abbreviations, acronyms and definitions used in the Residential Options Waiver (ROW) manual chapter.

Abuse (adult/elderly) – The infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered. (La. R.S. 15:1503).

Abuse (child) – Any of the following acts which seriously endanger the physical, mental, or emotional health and safety of the child including:

1. The infliction or attempted infliction, or as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon the child by a parent or by any other person;
2. The exploitation or overwork of a child by a parent or by any other person; and/or
3. The involvement of a child in any sexual act with a parent or with any other person. Abuse also, includes the aiding or toleration by a parent or the caretaker of the child's sexual involvement with any other person, including the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Louisiana Children's Code Article 603).

Activities of Daily Living (ADL) – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility, and eating. The extent to which a person requires assistance to perform one or more ADL often is a level of care (LOC) criterion.

Advocacy – The process of ensuring that beneficiaries receive appropriate, high quality services and locating additional services needed by the beneficiary which are not readily available in the community.

Appeal – A due process system of procedures which ensures that a beneficiary will be notified of and have an opportunity to contest a Louisiana Department of Health (LDH) decision.

Applicant – An individual whose written application for Medicaid or LDH funded services has been submitted to LDH but whose eligibility has not yet been determined.

Assessment – One or more processes that are used to obtain information about a person, including their condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information

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supports the determination that a person requires waiver services as well as the development of the plan of care (POC).

Authorized Representative – A person designated by a beneficiary (by use of a designation form) to act on their behalf with respect to their services.

Beneficiary – An individual who has been certified for medical benefits by the Medicaid Program. A beneficiary certified for Medicaid waiver services may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) – The Bureau within LDH responsible for the administration of the Louisiana Medicaid Program.

BPS – Bureau of Protective Services.

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for Federal administration of the Medicaid, Medicare, and State Children’s Health Insurance Program (SCHIP) programs.

Change of Ownership (CHOW) – Any change in the legal entity responsible for operation of a provider agency.

Claim – A request for payment for services rendered.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a beneficiary (La. R.S. 40:2009.14).

Confidentiality – The process of protecting a beneficiary’s or an employee’s personal information, as required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and by Louisiana law.

Corrective Action Plan – Written description of action a direct service provider (DSP) agency plans to take to correct deficiencies identified by the local governing entity (LGE), Office for Citizens with Developmental Disabilities (OCDD), or LDH.

Critical Incident – An alleged, suspected or actual occurrence of: (a) abuse (including physical, sexual, verbal and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to beneficiary’s health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.

De-certification – Removal of a beneficiary from the waiver by OCDD due to the inability of waiver services to ensure a beneficiary’s health and safety in the community or due to non-compliance with waiver requirements by the beneficiary. Decertification of a waiver beneficiary

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is subject to review by the State Office Review panel prior to notification of appeal rights and subsequent termination of waiver services.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and other health programs.

Developmental Disability – See Appendix A.

Diagnosis and Evaluation (D&E) – A process conducted by an appropriate professional to determine a person’s level of disability and to make recommendations for remediation.

Direct Service Provider (DSP) – A public or private licensed organization/entity that is enrolled as a Medicaid provider to furnish services to beneficiaries using its own employees (direct support workers (DSWs)).

Direct Support Worker (DSW) – A person who is paid to provide direct services and active supports to a beneficiary.

Discharge – A beneficiary’s removal from the waiver for reasons established by OCDD.

Durable Medical Equipment (DME) – DME covered under the Medicaid State Plan.

Eligibility – The determination of whether or not a person qualifies to receive waiver services based on meeting established criteria for the target group as set by LDH.

Electronic Visit Verification (EVV) – A computer based system that records the actual time that the provision of waiver services begins and ends. Louisiana Service Reporting System (LaSRS®) is the state sponsored system that is mandatory for some waiver services, as identified in the program manual. Providers may request permission from BHSF and OCDD to use their own EVV system for mandatory services. Approval will only be granted for EVV systems that meet minimum standards established by the department.

Emergency Backup Plan – Provision of alternative arrangements for the delivery of services that are critical to a beneficiary’s well-being in the event that the DSW responsible for furnishing the services fails or is unable to deliver them.

Exploitation – The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of the person’s or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 15:1503).

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation or abuse of legal or official authority.

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Extraordinary Care - Exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the beneficiary and avoid institutionalization.

Fiscal/Employer Agent (F/EA) – A term used by the Internal Revenue Service (IRS) for entities that perform tax withholding for employers.

Force Majeure – An event or effect that cannot be reasonably anticipated or controlled.

Freedom of Choice (FOC) – The process that allows a beneficiary the choice between institutional or home and community based services and to review all available support coordination and service provider agencies in order to freely select agencies of their choice.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule – A Federal regulation designed to provide privacy standards to protect patient’s medical records and other health information provided to health plans, doctors, hospitals, and other healthcare providers.

Home and Community-Based Services (HCBS) – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirement of an institutional LOC. It provides a collection of supports and services available through an approved CMS waiver that are provided in a community setting through enrolled providers of specific Medicaid services.

Individual Budget – An amount of dollars over which the beneficiary or their authorized representative exercises decision-making authority concerning the selection of services, service providers, and the amount of services (self-direction option).

Individualized Service Plan (ISP) – The ISP has been replaced by the provider documents contained in the POC. See the definition for POC.

Institutionalization – The placement of a beneficiary in an inpatient facility including a hospital, group home for people with intellectual disabilities, nursing facility, or psychiatric hospital.

Interdisciplinary Team (IDT) – The group of professionals involved in assessing the needs of a high risk beneficiary and making recommendations in a team staffing for services or interventions targeted at those needs, which is also referred to as **Multi-disciplinary Team (MDT)**.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A public or private facility that provides health and habilitation services to people with intellectual disabilities. ICFs/IID have four or more beds and provide “active treatment” to their residents.

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Inventory for Client & Agency Planning (ICAP) - Standardized assessment instrument that is designed to assess the status, adaptive functioning, adaptive and maladaptive behavior and service needs of an individual. The ICAP score provides input for the ISP development and sets the budget limitation for the individual's services plans. The ICAP is applicable to participants of all ages (infant to adult).

ICAP Acuity Level - Score from the ICAP assessment to determine reimbursement rates specific to 4 acuity levels of need (intermittent, limited, extensive, pervasive) identified in the ICAP. Those same acuity levels and rates are applied to ROW participants living in the community.

Level of Care (LOC) – The specification of the minimum amount of assistance that a person require in order to receive services in an institutional setting under the Medicaid State Plan.

Licensure – A determination by the Health Standards Section (HSS) that a service provider agency meets the requirements of State law to provide services.

Linkage – The act of connecting a beneficiary to a specific support coordination or service provider agency.

Local Governing Entity (LGE) – The regional office, routinely referred to as the human services authority or district responsible for single point of entry, implementation, and oversight of the ROW on behalf of OCDD. There is one LGE for each service region. Refer to Appendix C to obtain the contact information for the LGE in your area.

Louisiana Department of Health (LDH) – The state agency responsible for administering the state's Medicaid program and other health and related services including, but not limited to, public health, behavioral health, developmental disabilities, and addictive disorder services.

Louisiana Rehabilitation Services (LRS) – The agency under the Louisiana Workforce Commission charged with providing vocational rehabilitation services to qualified persons.

LTC – Long Term Care.

Medicaid – A federal-state medical assistance entitlement program provided under a State plan approved under Title XIX and XXI of the Social Security Act.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by the LDH. (La. R.S. 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. The system is an organized method of

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payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the beneficiary’s ADL (La. R.S. 40.2009.14).

Monitoring – The ongoing oversight of the provision of waiver services to ensure that they are furnished according to the beneficiary’s approved POC and effectively meet their needs.

Native Language – The language normally used by the beneficiary and their support network, which may include, but not limited to, American or English Sign Language and other non-verbal forms of communication.

Natural Supports – Persons who are not paid to assist a beneficiary in achieving their personal outcomes regardless of their relationship to the beneficiary.

Neglect (adult/elderly) – The failure of a care giver who is responsible for an adult's care or by other parties, or by the adult beneficiary’s action or inaction to provide the proper or necessary support or medical, surgical, or any other care necessary for their well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S.15:1503).

Neglect (child) – The refusal or failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment or counseling for an injury, illness, or condition of the child, as a result of which the child’s physical, mental, or emotional health and safety is substantially threatened or impaired. The inability of a parent or caretaker to provide for a child due to inadequate financial resources shall not, for that reason alone, be considered neglect. Whenever, in lieu of medical care, a child is being provided treatment in accordance with the tenets of a well – recognized religious method of healing which has a reasonable, proven record of success, the child shall not, for that reason alone, be considered neglected or abused. (Children’s Code Article 603). Disagreement by the parents regarding the need for medical care, shall not by itself, be grounds for termination of parental rights. (Children’s Code Article 1003).

OCDD Eligibility Determination (Form 90-L) – The form that is signed by a Louisiana licensed physician, nurse practitioner (NP), or physician assistant and used by Medicaid to establish a LOC. In the Waiver programs, a beneficiary must meet an ICF/IID LOC in order to be offered a waiver opportunity.

Office for Citizens with Developmental Disabilities (OCDD) – The operating agency responsible for the day-to-day operation and administration of the OCDD Waiver programs.

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Outcome – The result of performance (or non-performance) of a function or process.

Person-Centered Planning – A POC process directed and led by the beneficiary or their authorized representative designed to identify their strengths, capacities, preferences, needs, and desired outcomes.

Personal Outcomes – Results achieved by or for the waiver beneficiary through the provision of services and supports that make a meaningful difference in the quality of their life.

Plan of Care (POC) – A written plan designed by the beneficiary, their authorized representative, service provider(s), and others chosen by the beneficiary, and facilitated by the support coordinator that lists all paid and unpaid supports and services. It also identifies broad goals and timelines identified by the beneficiary as necessary to achieve their personal outcomes. Also included in the POC are specific actions required by the provider agency to assist in achieving the personal outcomes defined by the beneficiary as well as tasks to support daily living and ensure health and safety.

Plan of Correction – A plan developed by a provider in response to deficient practice citations. Required components of the Plan of Correction include the following:

1. What corrective actions will be accomplished for those waiver beneficiaries found to have been affected by the deficient practice;
2. How other beneficiaries being provided services and support who have the potential to be affected by the deficient practice will be provided corrective care resulting from the Plan of Correction;
3. The measures that will be put into place or the systemic changes that will be made to ensure that the deficient practice will not recur; and
4. How the corrective measures will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place regarding the identified deficient practice.

Pre-certification Visit – The visit the LGE makes to the residence of the applicant, where at a minimum the applicant and, if appropriate, their representative(s) are in attendance in order to ensure that waiver planning and services, rights, responsibilities, methods of filing grievances and/or complaints, abuse/neglect and possible means of relief have been fully explained and that all parties are in agreement to move forward with waiver services.

Prior and Post Authorization (PA) - The authorization for service delivery based on the beneficiary's approved POC. PA must be obtained before any waiver services can be provided and post authorization must be approved before services delivered will be paid.

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Procedure Code – A code used to identify a service or procedure performed by a provider.

Provider/Provider Agency – An individual or entity furnishing Medicaid services under a provider and/or licensing or certification agreement.

Quality Assurance/Quality Enhancement (QA/QE) Program: - A program that assesses and improves the equity, effectiveness, and efficiency of waiver services in a fiscally responsible system, with a focus on the promotion and attainment of independence, inclusion, individuality, and productivity of persons receiving waiver services, and accomplishes these goals through standardized and comprehensive evaluations, analyses, and special studies.

Quality Improvement (QI) – The performance of discovery, remediation, and quality improvement activities in order to ascertain whether the service provider agency meets assurances, corrects shortcomings, and pursues opportunities for improvement.

Quality Management – The section within OCDD whose responsibilities include the activities to promote the provision of effective services and supports on behalf of beneficiary and to assure their health and welfare. Quality management activities ensure that program standards and requirements are met.

Reassessment – A core element of services defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and redesigning the overall POC.

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible beneficiary.

Request for Services Registry (RFSR) – A registry maintained by the OCDD that includes the dates of request and the names of individuals who have been determined to meet the Louisiana definition for developmental disability and wish to receive services in a waiver program.

Residential Options Waiver (ROW) – A 1915(c) waiver designed to provide HCBS to beneficiaries who otherwise would require the LOC of an ICF/IID.

Screening for Urgency of Need (SUN) – The tool used by OCDD to determine the urgency of need of individuals on the RFSR. The score received on the SUN is used for prioritization in making waiver offers.

Self-Neglect – The failure, either by the adult’s action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing

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in lieu of medical treatment shall for that reason alone be considered to be self-neglected (La. R.S. 15:1503).

Sexual Abuse – Any sexual activity between a beneficiary and staff without regard to consent or injury; any non-consensual sexual activity between a beneficiary and another person, or any sexual activity between a beneficiary and another beneficiary, or any other person when the beneficiary lacks the capacity to consent. Sexual activity includes, but is not limited to, kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; and request, suggestion, or encouragement by another person for the beneficiary to perform sex with any other person when beneficiary is not competent to refuse.

Single Point of Entry (SPOE) – The OCDD regional offices, LGE where the entry point for all developmental disability services, including home and community-based waivers, is made.

Statement of Approval (SOA) – Previously known as a Statement of Eligibility (SOE). Statement issued by the SPOE confirming the date the individual has been determined to meet the Louisiana definition for developmental disability.

Support Coordination – Services provided to eligible beneficiaries to help them gain access to the full range of needed services including medical, social, educational and other support services. Activities include, but are not limited to, assessment, POC development, service monitoring, and assistance in accessing waiver, Medicaid State Plan, and other non-Medicaid services and resources.

Support Coordinator – An individual meeting qualifications required by LDH who is employed by a qualified Support Coordination Agency that provides support coordination services.

Support Team – A team comprised of the beneficiary, the beneficiary’s legal representative(s), family members, friends, support coordinator, DSPs, medical and social work professionals as necessary, and other advocates, who assist the beneficiary in determining needed supports and services to meet the beneficiary’s identified personal outcomes. Medical and social work professionals may participate by report. All other support team members must be active beneficiaries.

Surveillance Utilization Review System (SURS) – The program operated by the LDH Fiscal Intermediary (FI) in partnership with the Program Integrity Section, which reviews provider’s compliance with Louisiana Medicaid policies and regulations, including investigating allegations of fraud, waste, and abuse.

Title XIX – The section of the Social Security Act, which authorizes the Medicaid Program.

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Transition – The steps or activities conducted to support the passage of the beneficiary from existing formal or informal services to the appropriate level of services, including disengagement from all services.

Waiver – An optional Medicaid program established under Section 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional LOC.

Waiver Service – An approved service in a home and community-based waiver provided to an eligible beneficiary that is designed to supplement, not replace, the beneficiary’s natural supports.

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OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Officer for Citizens with Developmental Disabilities (OCDD) Central State	Operating agency responsible for the statewide operation and administration of the OCDD waiver programs.	<p style="text-align: center;">OCDD PO Box 3117, Bin #21 Baton Rouge, LA 70821-3117</p> <p style="text-align: center;">Phone: (225) 342-0095 Toll-Free: 1-866-783-5553 Fax: (225) 342-8823 E-Mail: ocddinfo@la.gov</p>
Local Governing Entity (LGE) routinely referred to as Human Service Districts and Authorities	Regional office responsible for Single Point of Entry, implementation and oversight of the Residential Options Waiver (ROW) on behalf of OCDD.	http://ldh.la.gov/index.cfm/page/134
Louisiana Department of Health (LDH) - Health Standards Section (HSS)	Office to contact to report changes that affect provider license.	LDH/HSS P.O. Box 3767 Baton Rouge, LA 70821 or (225) 342-0138 Fax: (225) 342- 5073
Division of Administrative Law – LDH	Office to contact to file an appeal request.	Division of Administrative Law - LDH P. O. Box 44033 Baton Rouge, LA 70804-4033 (225) 342-1800 Fax: (225) 342-1812
Gainwell Technologies Provider Enrollment Section	Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer.	Gainwell Technologies Provider Enrollment Section P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370

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APPENDIX C: CONTACT INFORMATION

<p>Gainwell Technologies Provider Relations Unit</p>	<p>Office to contact to obtain assistance with questions regarding billing information</p>	<p>Gainwell Technologies Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or 225-924-5040</p>
<p>Healthy Louisiana (MEDICAID MANAGED CARE ORGANIZATIONS (MCOs))</p>	<p>Healthy Louisiana (previously called Bayou Health) is the way most of Louisiana's Medicaid and LA CHIP beneficiaries receive health care services. In Healthy Louisiana, Medicaid beneficiaries enroll in a managed care plan.</p>	<p>http://ldh.la.gov/index.cfm/subhome/6</p>
<p>Medicaid Program Integrity</p>	<p>Office to contact to report fraud, waste or abuse</p>	<p>Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://ldh.la.gov/index.cfm/page/219</p>
<p>Louisiana State Adverse Actions List Search with Direct Service Worker (DSW) Registry information</p> <p>And</p> <p>Office of the Inspector General (OIG)</p>	<p>Verification of exclusion or restriction from government funded health program and verification of findings which excludes DSW from working with waiver beneficiaries.</p> <p>Note: Provider MUST search both for each worker upon hire and every month thereafter and must maintain documentation of these checks.</p>	<p>https://adverseactions.ldh.la.gov/SelSearch and https://exclusions.oig.hhs.gov/</p>

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APPENDIX C: CONTACT INFORMATION

<p>Federal System Award Management</p>	<p>Verification of exclusion or restriction of Vendors from government funded programs.</p> <p>Note: Provider MUST search upon hire and every month thereafter and must maintain documentation of these checks.</p>	<p>https://www.sam.gov/portal/SAM/</p>
<p>Department of Children and Family Services (DCFS) - Local Child Protection Hotline</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary under the age of 18.</p>	<p>Refer to the DCFS Services website at: http://www.dss.la.gov under the “Report Child Abuse/Neglect” link</p>
<p>Adult Protective Services</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary age 18-59 or an emancipated minor.</p>	<p>LDH Office of Aging and Adult Services (OAAS) 1-800-898-4910</p>
<p>Elderly Protective Services</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary age 60 or older.</p>	<p>Governor’s Office of Elderly Affairs 1-833-577-6532</p>
<p>Myers and Stauffer’s, LLC</p>	<p>Information about filing cost reports.</p>	<p>https://www.mslc.com/Louisiana/HCBS.aspx</p>
<p>Statistical Resources, Inc.</p>	<p>Entity to contact regarding: Louisiana Services Reporting System (LaSRS®), Electronic Visit Verification (EVV) Process, Prior/Post Authorization, and Billing Issues.</p>	<p>11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501</p>

OCDD

Contact information for the central office and the local governing entities (LGEs) are found on the OCDD website at: <http://dhh.louisiana.gov/index.cfm/page/134/n/137>

FORMS/WEBSITES

Forms used in the Residential Options Waiver (ROW) program can be obtained from the Louisiana Department of Health (LDH) website at:

<https://ldh.la.gov/page/4361>

1. Environmental Accessibility Adaptation Job Completion Form;
2. Specialized Medical Equipment and Supplies Purchase and Repair Form;
3. Rights and Responsibilities for Individuals Requesting Home and Community-Based Services (HCBS);
4. Transitional Expenses Planning and Approval (TEPA) Request Form;
5. TEPA Invoice Form;
6. Office for Citizens with Developmental Disabilities (OCDD) Verification of Actual TEPA Costs;
7. Universal Plan of Care (POC) including provider documents;
8. LDH-OCDD Revision Request Form;
9. POC Revision Request Form Instructions;
10. OCDD 90-L Medical Eligibility form documenting level of care (LOC) for services;
11. Beneficiary's Consent for Authorized Representation; and
12. Monitored in Home Caregiving (MIHC) Form.

Web Reference Information

Information about **reporting critical incidents** can be obtained from the OCDD Critical Incident Reporting for Waiver Services at the following LDH website:

<https://ldh.la.gov/page/critical-incident-reporting>

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APPENDIX D: FORMS/WEBSITES

The **Quality Enhancement Provider Handbook** can be obtained from the LDH website:

<http://ldh.la.gov/assets/docs/OCDD/waiver/QEProviderHandbook080108.pdf>

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APPENDIX E: BILLING CODES

BILLING CODES

The following chart describes the codes and rates that are to be used with the Residential Options Waiver (ROW). Providers must bill the appropriate procedure code for the service performed.

HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Support Coordination										
Case Management	45	81	4W	Support Coordination	T1016			\$176.79	1 flat monthly	12 annually
Transition Funding										
Community Transition Waiver	2	4A		One time transition service	T2038			\$3000		Life time maximum limit
Community Living Supports (Residential)										
Attendant Care Services	82	82	4W	Community Living Supports – 1 Person	S5125			\$4.63	15 min	
Attendant Care Services	82	82	4W	Community Living Supports – 2 Persons	S5125	UN		\$3.31	15 min	
Attendant Care Services	82	82	4W	Community Living Supports – 3 persons	S5125	UP		\$2.71	15 min	
Host Home Services-Children under 18 (Residential)										
Foster Care	84	84	4W	Host Home Level 1	S5140	HA		\$52.95	Per diem	
Foster Care	84	84	4W	Host Home Level 2	S5140	TF	HA	\$57.05	Per diem	
Foster Care	84	84	4W	Host Home Level 3	S5140	TG	HA	\$64.11	Per diem	
Foster Care	84	84	4W	Host Home Level 4	S5140	U2	HA	\$68.95	Per diem	

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Host Home Services-Adults 18 and over (Residential)										
Foster Care Adult	84	84	4W	Host Home Level 1	S5140			\$52.67	Per diem	
Foster Care Adult	84	84	4W	Host Home Level 2	S5140	TF		\$57.05	Per diem	
Foster Care Adult	84	84	4W	Host Home Level 3	S5140	TG		\$64.11	Per diem	
Foster Care Adult	84	84	4W	Host Home Level 4	S5140	U2		\$69.32	Per diem	
Companion Care Services (Residential)										
Companion Care, Adult	82	82	4W	Companion Care	S5136			\$92.02	Per diem	
Shared Living Services-New (Up to 3 people) Provider Leased or Owned Residence (Residential)										
Habilitation, Residential	11	4A	4G	Shared Living – Level 1	T2016			\$82.33	Per diem	
Habilitation Residential	11	4A	4G	Shared Living – Level 2	T2016	TF	HQ	\$90.81	Per diem	
Habilitation Residential	11	4A	4G	Shared Living – Level 3	T2016	TG	HQ	\$104.08	Per diem	
Habilitation Residential	11	4A	4G	Shared Living – Level 4	T2016	U2	HQ	\$123.09	Per diem	
Shared Living-New (Up to 3 people) Participant Leased or Owned Residence (Residential)										
Habilitation, Residential	11	4A	4L	Shared Living – Level 1	T2016	HQ		\$82.33	Per diem	
Habilitation Residential	11	4A	4L	Shared Living – Level 2	T2016	TF	HQ	\$90.81	Per diem	

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Shared Living-New (Up to 3 people) Participant Leased or Owned Residence (Residential) continued										
Habilitation Residential	11	4A	4L	Shared Living – Level 3	T2016	TG	HQ	\$104.08	Per diem	
Habilitation Residential	11	4A	4L	Shared Living – Level 4	T2016	U2	HQ	\$123.09	Per diem	
Shared Living-Conversion/Provider Leased or Owned Residence (Residential)										
Residential Care, (NOS), Waiver	11	4A	4J	Shared Living – Level 1 Up to 4 people	T2033	UQ		\$61.81	Per diem	
Residential Care, (NOS), Waiver	11	4A	4J	Shared Living – Level 2 Up to 4 people	T2033	TF	UQ	\$70.09	Per diem	
Residential Care, (NOS), Waiver	11	4A	4J	Shared Living – Level 3 Up to 4 people	T2033	TG	UQ	\$84.86	Per diem	
Residential Care, (NOS), Waiver	11	4A	4J	Shared Living – Level 4 Up to 4 people	T2033	U2	UQ	\$111.26	Per diem	
Shared Living-Conversion/Participant Leased or Owned Residence (Residential)										
Residential Care, (NOS), Waiver	11	4A	4H	Shared Living – Level 1 Up to 4 people	T2033	UQ		\$61.81	Per diem	
Residential Care, (NOS), Waiver	11	4A	4H	Shared Living – Level 2 Up to 4 people	T2033	TF	UQ	\$70.09	Per diem	
Residential Care, (NOS), Waiver	11	4A	4H	Shared Living – Level 3 Up to 4 people	T2033	TG	UQ	\$84.86	Per diem	
Residential Care, (NOS), Waiver	11	4A	4H	Shared Living – Level 4 Up to 4 people	T2033	U2	UQ	\$111.26	Per diem	

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Respite Services										
Respite Care Services	83	83		Respite Care Services-Out of Home	T1005	HQ		\$3.50	15 min	720 hours
Personal Emergency Response System										
Personal Emergency Response System	16	90		Installation	S5160			\$30.00	Installation	
Personal Emergency Response System	16	90		Monthly Service Fee	S5161			\$27.00	Monthly	
Transportation (Residential Services)										
Transportation Local Trip	42	4X 4A	4W	Transportation Regular - (Comm Access)	T2001	U1		\$5.58	One-way	730
Transportation -Local Trip (W/C)	42	4X 4A	4W	Transportation Wheel chair - (Comm Access)	A0090			\$9.32	One-way	730
Adaptation/Accessibility Services										
Assistive Technology/ Specialized Medical Equipment	17	91		Assistive Technology Specialized Medical Equip. and Supplies	T2029				Per Item/ Service	
Specialized Medical Equipment, Not otherwise specified (NOS)	17	91		Repairs Specialized Medical Equipment and Assistive Technology	T2029	RB			Per Item/ Repair	
Environmental Modifications	15	80		Environmental Accessibility Adaptations	S5165				Per Service	
Remote Supports	17	91		Mobile Emergency response system Purchase	S5162				One Time	
Remote Supports	17	91		Mobile Emergency Response System Purchase	S5162	XU		\$50.00	Monthly	
Remote Supports	17	91		Assistive Technology Supports Consultation	T2035			\$200	One time per POC Year	Cannot be provided in same POC year as T1028

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Adaptation/Accessibility Services										
Remote Supports	17	91		Home environment assessment	T1028			\$450.00	One Time	Cannot be provided in same POC year as T2035
Remote Supports	17	91		Med reminder serv per month	S5185			\$75.00	Monthly	
Remote Supports	17	91		Monitoring feature/device noc	A9279				One Time	
Remote Supports	17	91		Monitoring feature/device noc interactive audio and video	A9279	GT			One Time	
Remote Supports	17	91		Alert device, noc	A9280				One Time	
Incontinence Supplies	17	91		Adult size brief/diaper sm	T4521			\$0.50		
Incontinence Supplies	17	91		Adult size brief/diaper med	T4522			\$0.60		
Incontinence Supplies	17	91		Adult size brief/diaper lg	T4523			\$0.87		
Incontinence Supplies	17	91		Adult size brief/diaper xl	T4524			\$0.87		
Incontinence Supplies	17	91		Adult size pull-on sm	T4525			\$0.85		
Incontinence Supplies	17	91		Adult size pull-on med	T4526			\$0.85		
Incontinence Supplies	17	91		Adult size pull-on lg	T4527			\$0.94		
Incontinence Supplies	17	91		Adult size pull-on xl	T4528			\$1.17		

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Adaptation/Accessibility Services										
Incontinence Supplies	17	91		Disposable liner/shield/pad	T4535			\$0.46		
Incontinence Supplies	17	91		Large disposable underpad	T4541			\$0.46		
Incontinence Supplies	17	91		Small disposable underpad	T4542			\$0.46		
Incontinence Supplies	17	91		Adult disp brief/diap avb xl	T4543			\$2.49		
Incontinence Supplies	17	91		Adlt disp und/pull on avb xl	T4544			\$2.49		
Incontinence Supplies	17	91		Incon disposable penile wrap	T4545			\$1.25		
Incontinence Supplies	17	91		Reusable pull-on any size	T4536			\$0.76		
Incontinence Supplies	17	91		Reusable underpad bed size	T4537			\$8.73		
Incontinence Supplies	17	91		Reusable diaper/brief any size	T4539			\$2.49		
Incontinence Supplies	17	91		Reusable underpad chair size	T4540			\$10.00		
Day and Employment Services										
Supported Employment	98	98		Group Employment	H2025			\$2.76	15 Min	32 Units per Day
Supported Employment	98	98		Work Based Learning Experience	H2023	UK	UI	\$175.00	Per Assessment	3
Supported Employment	98	98		Job Development/Job Placement	H2023	U1		\$20.00	15 minute	480 units

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Supported Employment	98	98		Initial Job Support And Job Stabilization	H2023	TS	U1	\$18.50	15 minute	1,920
Supported Employment	98	98		Extended On The Job Supports	H2023	TT	U1	\$15.00	15 minute	2,500
Supported Employment	98	98		Follow Along Job Supports	H2026	U1		\$70.00	Per Diem	48
Supported Employment	98	98		Virtual Delivery of Follow Along Job Supports	H2023	GT	U1	\$13.63	15 minute	960
Non-Emergency Transportation	98	98		Regular Transportation for Supported Employment Services	T2002			\$20.00	Per Day	
Habilitation, Prevocational	13	36		Pre-Vocational Onsite in a 1:5-8 ratio	T2025			\$2.39	15 Min	32 Units per Day, shared among all H2014 codes
Non-Emergency Transportation	13	36		Regular Transportation for Prevocational Services	T2002			\$20.00	Per Day	
Habilitation, Prevocational	13	36		Virtual Delivery of Pre-Vocational in a 1:5-8 ratio	T2025	GT		\$2.98	15 Min	32 Units per Day, shared among all H2014 codes
Habilitation, Prevocational	13	36		Community Career Planning in a ratio of 1:2-4 ratio	T2025	UQ		\$4.50	15 Min	32 Units per Day, shared among all H2014 codes
Habilitation, Prevocational	13	36		Community Career Planning in a ratio of 1:1 ratio	H2014	TT		\$5.00	15 min	32 Units per Day, shared among all H2014 codes
Day Habilitation	14	50		Day Habilitation Onsite in a 1:5-8 ratio	T2021			\$2.48	15 Min	32 Units per Day shared among all T2021 codes
Day Habilitation	14	50		Virtual Delivery of Day Habilitation 1: 5-8 ratio	T2021	GT		\$2.98	15 Min	32 Units per Day shared among all T2021 codes
Day Habilitation	14	50		Community Life Engagement in a Ratio of 1: 1 ratio	T2021	TT		\$4.75	15 Min	32 Units per Day shared among all T2021 codes

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Day Habilitation	14	50		Community Life Engagement in a Ratio of 1: 2-4 ratio	T2021	UQ		\$4.00	15 Min	32 Units per Day shared among all T2021 codes
Non-Emergency Transportation	14	50		Regular Transportation for Day Habilitation	T2002			\$20.00	Per Day	
Day Habilitation	14	50		Community Life Engagement Development (1:1 ratio)	T2025	UI		\$7.00	15 minute	240 shared among all T2025 codes
Day Habilitation	14	50		Community Life Engagement Development (1:2 ratio)	T2025	UN		\$4.00	15 minute	240 shared among all T2025 codes
Day Habilitation	14	50		Community Life Engagement Development (1:3 ratio)	T2025	UP		\$3.00	15 minute	240 shared among all T2025 codes

HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Nursing Services										
In Home Nursing Care by LPN	44	87	4W	LPN-Intermittent Services (1 person)	G0300			\$71.44	Per visit	
	11	4A								
Services of Skilled Nurse In Home Health Setting	44	87	4W	LPN-Intermittent Services (up to 4 persons)	G0300	TT		\$35.70	Per visit	
	11	4A								
In Home Nursing Care by LPN	44	87	4W	LPN-Extended Services (1 person)	S9124			\$41.60	Per hour	
	11	4A								
In Home Nursing Care by LPN	44	87	4W	LPN-Extended Services (up to 2 persons)	S9124	TT		\$20.80	Per Hour	
	11	4A								
RN Intermittent Services	44	87	4W	Nursing RN (1 person)	G0299			\$89.51	Per visit	
	11	4A								
RN Extended Services	44	87	4W	Nursing RN (up to 2 persons)	S9123	TT		\$21.10	Per hour	
	11	4A								
RN Extended Services	44	87	4W	Nursing RN (1 person)	S9123			\$44.20	Per hour	
	11	4A								
RN Intermittent Services	44	87	4W	Nursing RN (up to 4 persons)	G0299	TT		\$44.62	Per visit	
	11	4A								

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Professional Services (Registered Dietician)										
Professional Services	41,11, 84	4R	4W	Registered Dietician (Individual)	97802			\$9.00	15 min	
Professional Services	41,11, 84	4R	4W	Registered Dietician (Individual, Subsequent)	97803			\$9.00	15 min	
Professional Services	41,11, 84	4R	4W	Registered Dietician (Group)	97804			\$9.00	15 min	

Professional Services (Speech Therapy)										
Professional Services	39	71	4W	Speech Therapy Evaluation of Speech Fluency (e.g. stuttering, cluttering)	92521			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy Evaluation of Speech sound production (e.g. articulation, phonological process, apraxia, dysarthria)	92522			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy Evaluation of Speech Sound Production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language)	92523			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy Behavioral and Qualitative Analysis of Voice and Resonance	92524			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Speech Language Hearing Therapy)	92507			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Laryngeal function studies)	92520			\$21.00	15 min	
	11	4A								
	84	84								

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Professional Services (Speech Therapy) continued										
Professional Services	39	71	4W	Speech Therapy (Oral function therapy)	92526			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Evaluation for non-speech device RX)	92605			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Non-speech device service)	92606			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Ex for speech device RX)	92607			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Evaluate swallowing function)	92610			\$21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Therapeutic activities)	97530	GN		\$2.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Cognitive skills development)	97129	GN		\$21.00	15 min	
	11	4A								
	84	84								
Professional Services (Occupational Therapy)										
Professional Services	37	74	4W	Occupational Therapy (OT Evaluation low complex 30 min)	97165			\$44.40	30 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (OT Evaluation mod complex 45min)	97166			\$66.60	45 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (OT Evaluation high complex 60 min)	97167			\$88.80	60 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (OT re-evaluation est plan of care)	97168			\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of hot or cold packs)	97010	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of Traction, Mechanical)	97012	GO		\$23.00	15 min	
	11	4A								
	84	84								

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Professional Services (Occupational Therapy) continued										
Professional Services	37	74	4W	Occupational Therapy (Application of electrical stimulation/ unattended)	97014	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of paraffin bath)	97018	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of whirlpool)	97022	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of electrical stimulation/ manual)	97032	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of iontophoresis)	97033	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of ultrasound)	97035	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (OT Therapeutic Procedure)	97110	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Massage therapy)	97124	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Manual therapy)	97140	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Therapeutic activities)	97530	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Cognitive skills development)	97129	GO		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Wheelchair management)	97542	GO		\$23.00	15 min	
	11	4A								
	84	84								

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Professional Services (Physical Therapy)										
Professional Services	35	65	4W	Physical Therapy (PT Evaluation low complex 20 min)	97161			\$29.60	20 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (PT Evaluation mod complex 30 min)	97162			\$44.40	30 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (PT Evaluation high complex 45 min)	97163			\$66.60	45 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (PT re-evaluation est plan of care)	97164			\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of hot or cold packs)	97010	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of traction, mechanical)	97012	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of electrical stimulation/ unattended)	97014	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of paraffin bath)	97018	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of whirlpool)	97022	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of electrical stimulation/ manual)	97032	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of iontophoresis)	97033	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of ultrasound)	97035	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Therapeutic Procedure)	97110	GP		\$23.00	15 min	
	11	4A								
	84	84								

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Professional Services (Physical Therapy) continued										
Professional Services	35	65	4W	Physical Therapy (neuromuscular re-education)	97112			\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Gait training)	97116			\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Massage therapy)	97124	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Manual therapy)	97140	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Therapeutic activities)	97530	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Wheelchair Management)	97542	GP		\$23.00	15 min	
	11	4A								
	84	84								
Professional Services (Social Work)										
Professional Services	73	73	4W	Social Worker (Family psychotherapy)	90847	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Group psychotherapy)	90853	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Self-care Management Training)	97535	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Community/ Work Reintegration)	97537	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Home visit assistance w/ADL's and personal care)	99509	AJ		\$18.00	15 min	
	11	4A								
	84	84								

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Professional Services (Social Work) continued										
Professional Services	73	73	4W	Social Worker (Home Visit, Sing/M/Fam Counseling)	99510	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Unlisted Home Visit Service or Procedure)	99600	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (HHCP-SVS of CSW)	G0155			\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Assertive Community treatment face to face)	H0039	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Mental Health Services, NOS)	H0046	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Crisis Intervention)	H2011	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Skilled Training and Development)	H2014			\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Psychosocial Rehab Services)	H2017	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Therapeutic Behavior Service)	H2019	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Community-based Wrap Around)	H2021	AJ		\$18.00	15 min	
	11	4A								
	84	84								
Professional Services (Psychology)										
Professional Services	31	62, 95,96		Psychologist (Interactive Psychological Diagnostic Interview)	90791			\$31.25	15 min	
	11	4A								
	84	84								

CHAPTER 38: RESIDENTIAL OPTIONS WAIVER

APPENDIX E: BILLING CODES

HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Professional Services (Psychology) continued										
Professional Services	31	62, 95,96	4W	Psychologist (Individual Psychotherapy)	90832			\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Family therapy without patient present)	90846			\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Special Family Therapy w/ patient)	90847	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Group Psychotherapy)	90853	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Pharmacologic Management)	90863			\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Psychological Testing by Psychologist)	96130			\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Psychological Testing by Tech)	96138			\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Neuropsychological testing)	96132			\$31.25	15 min	
	11	4A								
	84	84								

CHAPTER 38: RESIDENTIAL OPTIONS WAIVER

APPENDIX E: BILLING CODES

HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Professional Services (Psychology) continued										
Professional Services	31	62, 95,96	4W	Psychologist (Self-care Management Training)	97535	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Community/ Work Reintegration)	97537	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Home visit for Assistance with ADL's and Personal Care)	99509	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Home Visit, Sing/M/Fam Counseling)	99510	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Unlisted Home Visit Service or Procedure)	99600	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Assertive Community Treatment Face to Face)	H0039	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Mental Health Services, NOS)	H0046	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Crisis Intervention)	H2011	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Psychosocial Rehab Services)	H2017	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Therapeutic Behavior Service)	H2019	AH		\$31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Community-based Wrap Around)	H2021	AH		\$31.25	15 min	
	11	4A								
	84	84								

CHAPTER 38: RESIDENTIAL OPTIONS WAIVER

APPENDIX E: BILLING CODES

HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Permanent Supportive Housing Supports										
Permanent Supportive Housing	AW			Housing Stabilization	G9012			\$15.11	15 Min.	72 units annually
								\$60.44	1 Hour	
Permanent Supportive Housing	AW			Housing Stabilization Transition	G9012	U8		\$15.11	15 Min.	93 units annually
								\$60.44	1 Hour	
Adult Day Health Care (ADHC) Service										
Medical Rehabilitation Day Program	85	35	4W	Adult Day Health Care Center Based Service (ADHC)	S5100			\$2.78 Rate includes provider specific transportation rate	15 min	Max 40 unit per day
Monitored In-Home Care Giving										
Monitored In-Home Care Giving	MI	35		Waiver Service - not otherwise specified Level 1	T2033			\$90.03	per diem	
Monitored In-Home Care Giving	MI	35		Waiver Service - not otherwise specified Level 2	T2033	TG		\$135.04	per diem	
Monitored In-Home Care Giving	MI	35		Assessment	T1028	TU		\$250.00	one time	
Financial Management Services										
Financial Management Services (FMS) Monthly Administrative Fee	01			Financial Management Services	W7319			\$105.88	Monthly	

CLAIMS FILING

Hard copy billing of waiver services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

1. The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
2. The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and a sample of a completed CMS-1500 claim form; and
2. Instructions for adjusting/voiding a claim and a sample of an adjusted CMS-1500 claim form.

CMS-1500 (02/12) Instructions for Waiver Services

In order to access the CMS-1500 (02/12) Instructions for Waiver Services and to view sample forms, use the following link:

https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500.htm.

NOTE: You must write “WAIVER” at the top center of the claim form.

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.**

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice (RA), a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim;
or

CHAPTER 43: RESIDENTIAL OPTIONS WAIVER

APPENDIX F – CLAIMS FILING**PAGE(S) 6**

2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the RA

When an Adjustment/Void Form has been processed, it will appear on the RA under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the RA.

Sample forms are on the following pages.

CHAPTER 43: RESIDENTIAL OPTIONS WAIVER

APPENDIX F – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)



HEALTH INSURANCE CLAIM FORM

WAIVER

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA										PICA <input type="checkbox"/>	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>	MEDICAID (Medicaid #)	TRICARE (IDM/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS				3. PATIENT'S BIRTH DATE MM DD YY 07 31 72		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) CITY STATE				6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE					
ZIP CODE TELEPHONE (include Area Code)		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F					
b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		10b. AUTO ACCIDENT? PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)					
d. INSURANCE PLAN NAME OR PROGRAM NAME		10c. RESERVED FOR LOCAL USE		c. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME					
READ BACK OF FORM BEFORE SIGNING. THIS FORM IS FOR THE USE OF THE INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED DATE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0				22. RE SUBMISSION CODE A02 ORIGINAL REF. NO. 5299198798700		23. PRIOR AUTHORIZATION NUMBER Prior Auth#					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Rank	I. ID. QUAL.	J. RENDERING PROVIDER ID.#	
10 08 15 10 08 15 12		S5125 UN	A	90 00 30	NPI						
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 1234	27. ACCEPT ASSIGNMENT? (For gov. date, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 90 00		29. AMOUNT PAID \$	30. BALANCE DUE \$ 90 00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ima Biller DATE 10/15/15			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000					
a. 123967654			b. 1239876								

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CHAPTER 43: RESIDENTIAL OPTIONS WAIVER

APPENDIX F – CLAIMS FILING



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLX (LNU) <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. RESERVED FOR NUCC USE		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____ DATE _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____		15. OTHER DATE MM DD YY QUAL. _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
23. PRIOR AUTHORIZATION NUMBER _____		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS CPT UNITS H. ICD-9-CM Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SBN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____	
29. AMOUNT PAID \$ _____		30. Reason for NUCC Use _____	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____	
33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____			

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