



SUPPORTS WAIVER

Chapter Forty-Three of the Medicaid Services Manual

Issued June 10, 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 Supports Waiver (SW) is a 1915(c) waiver designed to enhance the home and community-based services (HCBS) and supports available to beneficiaries with developmental disabilities who require the level of care (LOC) of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The SW is funded by the Centers for Medicare and Medicaid Services (CMS), a federal agency, and matching state dollars. The waiver is operated by the Office for Citizens with Developmental Disabilities (OCDD) under the authorization of the Bureau of Health Services Financing (BHSF), both of which are under the Louisiana Department of Health (LDH).

The mission of this waiver is to create options and provide meaningful opportunities for individuals 18 years of age and older who have a developmental disability, through vocational and community inclusion. The waiver is available to provide:

1. The supports necessary in order for individuals to achieve their desired community living and work experience;
2. The services needed to acquire, retain, and/or improve self-help, socialization and adaptive skills; and
3. The beneficiary an opportunity to contribute to their community.

Objectives:

1. Promote independence for beneficiaries through the provision of services, which meet the highest standard of quality and are based on national best practices, while ensuring their health and welfare through a comprehensive system of 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 (not replacing) existing informal networks;
3. Support beneficiaries and their families to exercise their rights and share responsibility for their programs, regardless of the service delivery method;
4. Offer access to services on a short-term basis that would protect the health and welfare of beneficiaries if their families or caregivers are unable to continue to provide care and supervision; and

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5. Increase high school to community transition resources by offering supports and services to those 18 years and older.

Services provided through the waiver include the following:

1. Individual supported employment;
2. Group supported employment;
3. Onsite day habilitation;
4. Community life engagement;
5. Onsite prevocational;
6. Community career planning;
7. Habilitation;
8. Respite;
9. Housing stabilization transition;
10. Housing stabilization;
11. Personal emergency response system (PERS);
12. Support coordination (SC);
13. Adult dental services;
14. Specialized medical equipment; and
15. Community life engagement development.

All services must comply with the 42 CFR § 441.530 - Home and Community-Based Setting.

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Any residential or non-residential setting where individuals live and/or receive HCBS must demonstrate the following:

1. Integrate in and support full access of individuals to the greater community:
 - a. Provide opportunities to seek employment, work in competitive integrated settings, engage in community life, control personal resources; and
 - b. Ensure that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.
2. Selection by the individual from among setting options including non-disability specific settings and options for a private unit in a residential setting:
 - a. Person-centered service plan documents options based on the individual's needs, preferences, and for residential settings, resources available for room and board.
3. Ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
4. Optimize individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
5. Facilitate individual choice regarding services and supports and who provides them.

Beneficiaries have a choice of available SC agencies and provider agencies and are able to select enrolled qualified agencies through the Freedom of Choice (FOC) process.

The plan of care (POC) is developed using a person-centered planning process and identifies all of a beneficiary's needs, both non-funded and funded.

All natural supports, available community resources, and applicable Medicaid State Plan services must be exhausted prior to utilization of waiver funding. Also, if the beneficiary meets the criteria for the programs, the beneficiary must apply for, and exhaust any similar services available

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through Louisiana Rehabilitation Services (LRS) or the Individuals with Disabilities Education Act (IDEA).

Providers are required to follow the regulations and requirements as specified in this chapter, the SW Rule (LAC 50:XXI.Chapter 1), the Standards for Participation Rule for home and community-based waiver providers (LAC 50:XXI.Chapters 53-61) and all applicable licensure and/or certification requirements.

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BENEFICIARY REQUIREMENTS

To qualify for the Supports Waiver (SW), a person must be 18 years of age or older, be offered a waiver opportunity slot and adhere to all of the following eligibility criteria:

1. Meet the Developmental Disability Law criteria as defined in Appendix A;
2. Have their name on the Developmental Disabilities Request for Services Registry (DDRFSR);
3. Meet the financial and non-financial Medicaid eligibility criteria for Medicaid services;
4. Meet the medical requirements;
5. Meet the requirements for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care (LOC) which requires active treatment of a developmental disability under the supervision of a qualified intellectual disabilities professional;
6. Meet the determination that the SW is the Office for Citizens with Developmental Disabilities (OCDD) waiver, based on person-centered planning and a needs based assessment, that will meet the needs of the individual;
7. Meet the health and welfare assurance requirements for home and community-based services (HCBS); and
8. Be a resident of Louisiana.

To remain eligible for waiver services, a beneficiary must receive one or more waiver services every 30 days.

Developmental Disabilities Request for Services Registry

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots. Individuals who request waiver services are placed on a statewide DDRFSR and are selected for an OCDD waiver opportunity based on the urgency of need and earliest registry date.

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Requests for waiver services must be made from the applicant or their authorized representative by contacting the applicant's local governing entity (LGE).

When the LGE determines that the applicant's condition meets the definition of a developmental disability as defined by the Louisiana Developmental Disability Law, the applicant's name will be placed on the DDRFSR and the applicant/authorized representative will be sent a letter stating that the individual's name has been secured on the DDRFSR and informing them of the original request (protected) date. (See Appendix A for information regarding the Louisiana Developmental Disability Law). The individual will then undergo a screening for urgency of need (SUN). Entry into an OCDD waiver will be offered to applicants from the DDRFSR by urgency of need and the earliest request for services date. If, through the needs-based assessment, person centered planning process, and using the Tiered Waiver process, it is determined that the SW is the OCDD waiver that will meet the needs of the individual, the individual will be given a SW slot.

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

Applicants, or their authorized representatives, may verify their screening for urgency of need (SUN) score and request date by calling their local LGE. (See Appendix C for Contact Information).

Level of Care

The SW program is an alternative to institutional care. All waiver applicants must meet the definition of a person with an intellectual and/or developmental disability (IDD) as defined in Appendix A.

The LGE will issue either a Statement of Approval (SOA) or a Statement of Denial (SOD).

The Bureau of Health Services Financing (BHSF) "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 completed, signed, and dated by the individual's Louisiana licensed primary care physician (PCP). A licensed advanced nurse practitioner (NP), or a licensed physician's assistant (PA) may sign the 90-L, but the supervising or collaborating physician's name and address must be listed. The 90-L Form must be submitted with the individual's initial or annual plan of care (POC) to the LGE. The LGE is responsible for determining that the required LOC is met for each beneficiary.

The applicants/authorized representatives are ultimately responsible for obtaining the completed 90-L Form from the applicant's PCP. This form must be obtained prior to linkage to a support

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coordination (SC) agency for an initial POC and no more than 180 days before the annual POC start date.

Beneficiary Discharge Criteria

Beneficiaries will be discharged from the SW if one or more of the following criteria is met:

1. Loss of Medicaid eligibility as determined by the parish Medicaid Office;
2. Loss of eligibility for an ICF/IID LOC as determined by the LGE;
3. Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities;
4. Change of residence to another state with the intent to become a resident of that state;
5. Admission to an ICF/IID or nursing facility, without the intent to return to waiver services. 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 ICF/IID facility. Payment for SW services will not be authorized while the beneficiary is in an ICF/IID facility or nursing facility;
6. Determination by the LGE that the beneficiary's health and welfare cannot be assured in the community through the provision of reasonable amounts of waiver services, i.e. the beneficiary presents a danger to themselves or others;
7. Failure to cooperate in any eligibility determination process, the initial or annual implementation of the approved POC, or the responsibilities of the SW beneficiary; or
8. Continuity of stay is interrupted as a result of the beneficiary not receiving SW services for a period of 30 or more consecutive days. Continuity of stay will not apply to interruptions in waiver services because of hospitalization or institutionalization (such as admission to an ICF/IID or nursing facility) as long as there is documented expectation from the treating licensed physician that the

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beneficiary will return to waiver services no later than 90 days from admission to the hospital or institution.

In the case of an event or effect that cannot be reasonably anticipated or controlled (Force Majeure), SC agencies, service providers, and beneficiaries, whenever possible, will be informed in writing, and/or by phone, and/or via the Medicaid website, of interim guidelines and timelines for retention of waiver opportunities and/or temporary suspension of continuity of stay.

The service provider is required to notify the SC agency within 24 hours if the beneficiary has met any of the above stated discharge criteria.

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RIGHTS AND RESPONSIBILITIES

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

Support coordinators and service providers must assist beneficiaries with exercising their rights and responsibilities. Every effort must be made to ensure 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.

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), including employment. Individuals have a choice regarding services and supports, and who provides them.

Additional rights include, but are not limited to, the following:

1. Freedom and support to control their own schedule and activities;
2. Access to food at any time, unless contraindicated due to health and safety and documented in the plan of care (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 from employment.

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Rights and Responsibilities Form

For a complete list of the beneficiary's rights and responsibilities, 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 and at least annually thereafter.

Freedom of Choice

Applicants/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/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 SW program. In order to maintain eligibility, beneficiaries have the responsibility to inform BHSF of changes in their income, address, and living situation.

LDH - Office for Citizens with Developmental Disabilities (OCDD), through the local governing authority (LGE), 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.

Participation in Care

Support coordinators and service providers shall ensure that beneficiaries/authorized representatives participate in all person-centered planning meetings and any other meeting concerning their services and supports. Person-centered planning will be utilized in developing all services and supports to meet the beneficiary's unmet needs. By taking an active part in planning their services, the beneficiary is better able to utilize the available supports and services.

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

The support coordinator must request changes in the amount of services at least 10 days before the proposed changes take effect, except in the case of 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 that at the time of admission to the waiver and every 6 months thereafter, beneficiaries have the opportunity to change support coordination providers, if one is available. Beneficiaries may request a change by contacting the LGE.

Support coordinators will provide beneficiaries with their choice of direct service providers 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 SW program is to provide community-based services to individuals who would otherwise require institutionalization.

Compliance with Civil Rights

Providers shall operate in accordance with Titles VI and VII of the Civil Rights Act of 1964, as amended, 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 are 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 which, in any way, violate state or federal laws.

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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 beneficiaries may not violate the rights of providers.

Grievances/Fair Hearings

Each support coordination/direct service provider shall have grievance procedures through which beneficiaries may grieve the supports or services 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 and 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.

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SERVICE ACCESS AND AUTHORIZATION**Tiered Waiver Process**

When funding is appropriated for an 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 screening 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. At the conclusion of that process, if it is determined that the Supports Waiver (SW) is the most appropriate waiver for this individual, a SW offer will be extended.

The applicant will receive a waiver offer packet that includes a Support Coordination (SC) 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 the Medicaid data management contractor in order to be linked to a SC agency. The packet should include a current 90-L form that has been signed and dated by their primary care physician (PCP), nurse practitioner (NP), or physician's assistance (PA).

After the applicant is linked to a SC agency, the support coordinator will assist the applicant in gathering the documents that 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 and the availability of services, as well as the assistance provided through the support coordination service.

SW is the first waiver that is offered to adults, aged 18 (if no longer in high school and wanting to find employment) and older, in the tiered waiver process. When it has been determined the SW is the most appropriate waiver, another home visit is made to finalize the plan of care (POC). The following must be addressed in the POC:

1. Applicant's assessed needs;
2. Types and quantity of services (including waiver and all other services, both paid and unpaid) necessary to maintain the applicant safely in the community;
3. Individual cost of each waiver service; and
4. Total cost of waiver services covered by the POC.

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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 FOC form initially and annually thereafter for each identified waiver service.

Initial Plan of Care

The support coordinator is responsible for:

1. Notifying the provider that the beneficiary has selected their agency to provide the necessary service;
2. Scheduling a meeting with the provider and the beneficiary to discuss services needed by the beneficiary;
3. After the meeting, forwarding a copy of the draft POC and request the provider sign and return the following:
 - a. Budget pages; and
 - b. Required POC provider attachments 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 the 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 and supporting documentation will be forwarded to the LGE office.

NOTE: The authorization to provide a service is contingent upon approval by the LGE or support coordination supervisor.

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Prior Authorization

All services in the SW program must receive prior authorization (PA). PA is the process to approve specific services prior to service delivery and reimbursement for an enrolled Medicaid beneficiary by an enrolled Medicaid provider. The purpose of PA is to validate the service requested as being medically necessary and to verify that it meets the criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon passing all the edits contained within the claims payment process, 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 management 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 and any subsequent revision, which means that only the service codes and units specified in the approved POC will be considered for PA. Services provided without PA are not eligible for reimbursement.

The service provider is responsible for the following activities:

1. Checking PAs to ensure that all PAs for services match the approved services in the beneficiary's approved POC. Any mistakes must be corrected immediately to match the approved services in the POC;
2. Verifying that the direct service worker's (DSW) timesheet or electronic clock in/out is completed correctly and services were delivered according to the beneficiary's approved POC before billing for the service;
3. Verifying that services were documented 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;
4. Verifying service data in the electronic visit verification (EVV) system or LaSRS depending on the service and modifying the data, if needed, based on actual service delivery;
5. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;
 - a. 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

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and matches the information in LaSRS. Inconsistencies between LaSRS and provider's billing system may result in recoupment;

6. Billing only for the services that were approved in the beneficiary's POC and delivered to the beneficiary;
7. Reconciling all remittance advices (RAs) issued by the Louisiana Department of Health (LDH) fiscal intermediary (FI) with each payment; and
8. Checking billing records to ensure the appropriate payment was received.

NOTE: Service providers have a 1-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 and enter the required information into the billing system maintained by the Medicaid data management contractor. The Medicaid data management contractor checks the information entered into the billing system by the service provider against the prior authorized unit(s) of service. Once post authorization is granted, the service provider may bill the LDH FI for the appropriate unit(s) of service. Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

Changes in Service Needs

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

Changing Direct Service Providers

Beneficiaries/families may change direct service providers with the effective date being the beginning of a quarter. All requests for changes in services and/or service hours must be made by the beneficiary/family through the support coordinator.

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Direct service providers may be changed at any time for good cause as approved by the LGE.

Examples of good cause reasons include:

1. Beneficiary/family moving to another region in the state where the current direct service provider does not or cannot provide services;
2. Beneficiary/family and the direct service provider have unresolved difficulties and mutually agree to a transfer;
3. Beneficiary's health, safety or welfare have been compromised; or
4. Direct service provider has not rendered services in a manner satisfactory to the beneficiary/family.

The beneficiaries/families must contact their support coordinator to change direct service providers. The support coordinator will assist in facilitating a team meeting involving the current direct service provider(s) if agreed upon by the beneficiary/family.

This meeting will address the reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider will have the opportunity to submit a corrective action plan with specific time lines, not to exceed 30 days, to attempt to meet the needs of the beneficiary.

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

1. Provide the beneficiary/family with the current FOC list of service providers in their region;
2. Assist the beneficiary/family in completing the FOC and release of information form;
3. Ensure the current provider is notified immediately upon knowledge of the request and prior to the transfer; and
4. Obtain the case record from the releasing provider which must include:

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- a. Progress notes from the last 6 months, or if the beneficiary has received services from the provider for less than 6 months, all progress notes from date of admission;
- b. Written documentation of services provided, including monthly and quarterly progress summaries;
- c. Current POC;
- d. Records tracking beneficiary's progress towards POC goals and objectives;
- e. Behavior management plans, current and past if applicable;
- f. Documentation of the amount of authorized services remaining in the POC, including applicable time sheets; and
- g. Documentation of exit interview.

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

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

NOTE: Transfers must be made at least 7 days prior to the end of the service authorization quarter. The start date should be effective the first day of the new quarter in order to coordinate services and billing. The LGE may waive this requirement in writing due to good cause, at which time the start date will be the first day of the first full calendar month.

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.

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Prior Authorization for New Service Providers

The support coordinator will complete the POC revision form with the start date for the new provider and the end date for the transferring provider, and will submit the revision request to the LGE for approval.

Upon approval, a new PA number will be issued to the new provider with the effective start date agreed upon. 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 start date on the new PA 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 the change is due to good cause.

Changing Support Coordination Agencies

A beneficiary has the option to change SC agencies once every 6 months or at any time if there is "good cause." The beneficiary should notify the LGE office or contact the Medicaid data management contractor to request this change. Good cause is defined as:

1. Beneficiary/family moving to another region in the state;
2. Beneficiary/family and the support coordination agency have unresolved difficulties and mutually agree to a transfer;
3. Beneficiary's health, safety or welfare have been compromised; or
4. SC agency has not rendered services in a manner satisfactory to the beneficiary/family.

Participating SC agencies should refer to the SC section in this manual, which provides a detailed description of their roles and responsibilities.

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COVERED SERVICES

Supports Waiver (SW) services are designed to enhance the beneficiary's independence through involvement with employment and other community activities. All services must be based on need documented in the approved plan of care (POC), and provided within the state of Louisiana. The services that are available include:

1. Supported employment;
 - a. Individual supported employment:
 - i. Work based learning experience assessment;
 - ii. Job placement and job development;
 - iii. Extended job supports; and
 - iv. Follow along job supports – virtual delivery.
 - b. Group employment:
 - i. Group employment job assessment, discovery, and development.
2. Day habilitation:
 - a. Community life engagement (CLE) (1:2-4, 1:1); and
 - b. Onsite day habilitation (1:5-8).
 - i. Onsite day habilitation – virtual delivery.
3. Prevocational services:
 - a. Community career planning (CCP) (1:2-4, 1:1); and
 - b. Onsite prevocational (1:5-8).
 - i. Onsite prevocational services – virtual delivery.

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4. Respite;
 - a. Center-based and/or in-home.
5. Habilitation;
6. Housing stabilization transition services;
7. Housing stabilization services;
8. Personal Emergency Response System (PERS);
9. Support coordination (SC);
10. Expanded dental services;
11. Specialized medical equipment (incontinence supplies); and
12. Community Life Engagement Development (CLED).

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).

Supported Employment Services

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 with customers.

SE services are broken into 2 overarching categories:

1. Individual SE (1:1); and
2. Group employment (1:2, 1:3-4, or 1:5-8).

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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 options available for to beneficiaries who require 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 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 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 not waiver services that pay for the start-up costs of a business. The beneficiary

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should obtain assistance through vocational rehabilitation services or other programs. The employment provider may assist with 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.

Individual SE is conducted in a variety of settings, particularly at work sites in where individuals without disabilities are employed. When services are provided at a work site in where persons without disabilities are employees, 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 allows 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 hold someone up from finding employment in a timely manner.

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.

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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 3 areas of interests 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 ‘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 has been 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 3 assessments are allowed;
2. Provider must provide a copy of the ‘Work Based Assessment Form’ to the support coordinator and the local governing entity (LGE) so the SC can authorize payment in 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.

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. The exception is CLED is applicable.

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Staffing Ratio

This service is completed in a 1:1 ratio.

Service Limits

The standard unit is a ‘fee for each assessment’ completed.

1. Up to 3 assessments are allowed per POC year; and
2. Use of the EVV system is mandatory for all supported employment 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.

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.

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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 next phase, 'Initial Job Supports and Job Stabilization'.

Documentation Requirements

1. Each time the employment specialist contacts an employer, they should make an entry on the 'Job Development Employer Contact Activities Log';
2. Provider must give 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. '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 since the beneficiary does not have to be present for this service to occur.

Staffing Ratio

This service is completed in a 1:1 ratio.

Service Limits

1. 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 supported employment services. The EVV system requires the electronic check in/out in the LaSRS.

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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 as 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 Human Health Services (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 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.

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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 of the job. 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 direct service provider 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’s 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, assistive technology, 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 to the support coordinator and LGE;
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

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4. The employment specialist will complete the 'Job Stabilization Report' and submit to the support coordinator and the LGE and request a team meeting from the support coordinator to discuss the next phase of the supported employment 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 (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. 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 as 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;

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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 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' during 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 supported employment process, but is available to those beneficiaries who require the additional time in order to possibly become more independent in completing their job duties. The amount of support will vary depending on the support needs of the beneficiary and the frequency of this service may change and should be evaluated on an ongoing basis by the employment specialist. 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.

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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, whether it's 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 supports 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 supports is taking place; and
4. The beneficiary's quarterly meeting should include a discussion about the progress made over the last 3 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 (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

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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 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.

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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 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 direct service provider’s support, and any other employment supports the beneficiary is using. 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 provide 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.

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 (if applicable). The choice between virtual delivery and in person follow along job supports 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.

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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 is being delivered, 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 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. 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 the 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 direct service provider’s support, and any other employment supports the beneficiary is using. 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. Beneficiary must be informed of all persons who are present and the role of each person;
6. 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 the format 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, but that both services will not be billed at the same time.

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Documentation Requirements

1. Must use 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 (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. 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 beneficiaries in ratios of 1:1-2, 1:3-4, or 1:5-8. SE group services must be provided in a manner that promotes integration into the workplace and interaction between 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 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's documented that the beneficiary has chosen to work in the job and it's in the best interest for 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 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 from 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 used.

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

Place of Service

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

Restriction with Other Services

This service may not be billed at the same time on the same day as other services except for CLED (if applicable).

Staffing Ratio

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

Service Limits

1. The standard unit is a 15-minute increment;
2. 6,720 units are allowed per POC year; and
3. The 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. Transportation must be provided by the provider 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 (if applicable);

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6. The staff providing transportation cannot also be providing another service at the same time as providing transportation;
7. Use of the EVV system is not mandatory for this service; however, **transportation must be entered into 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 (ADC) by the Louisiana Department of Health (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.

Group Employment Job Assessment, Discovery, and Development

The job assessment, discovery, and development process includes:

1. Documented evaluation of the beneficiary and identifying an appropriate job;
2. Identifying appropriate employment options that match information gained from the beneficiary's assessment, profile, and/or plan;
3. Documented discussion of group employment and individual employment with the beneficiary;
4. Identifying specific career interests of the beneficiary; and
5. Ensuring the beneficiary understands that they may leave group employment at any time and has a choice of jobs.

The job assessment, discovery, and development phase allows the provider to provide beneficiaries, who think they might want to work as part of group employment, an opportunity to experience group employment work and to 'try out' various job opportunities that might be available in the community.

Group employment is not a required service. A beneficiary can choose not to pursue group employment at the end of the assessment, discovery and development phase.

The outcome of job assessment, discovery, and development is to develop a job opportunity that the beneficiary has chosen to pursue.

Place of Service

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

Restriction with Other Services

This service may not be billed at the same time on the same day as other services except for CLED.

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Staffing Ratio

This service is completed in a 1:1 ratio.

Service Limits

1. Standard unit is a 15-minute increment; and
2. 480 units are allowed per POC year.

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 cannot be provided at the same time another service is being delivered to the same beneficiary, with the exception of CLED (if applicable);
5. Staff providing transportation cannot also be providing another service at the same time as providing transportation; and
6. Use of the EVV system is not mandatory for this service, however, **transportation must be entered into 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 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

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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.

OR

1. Be licensed as an ADC 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
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.

Day Habilitation

Day habilitation services are focused on the beneficiary, and creating a meaningful day through the person-centered planning process. The process should support the beneficiary in how they choose to spend their time and what's 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 their community. Day habilitation activities may be educational or recreational in nature, which would include activities that are 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 of 1938 as amended. Volunteering is a great way for beneficiaries to become connected to their community and establish community relationships.

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

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Day habilitation services may be coordinated with needed therapies in the beneficiary's person-centered POC, such as physical therapy (PT). 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 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 2 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 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 2 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 figure 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.

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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 habilitation should be individualized with 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 only 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 not attend in person. Virtual delivery is

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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. HIPPA 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:

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. Verify beneficiary's identity;
4. Providers need the consent of the beneficiary prior to initiating a virtual service with the beneficiary;
5. Beneficiary must be informed of all persons who are present and the role of each person;
6. Beneficiaries may refuse services delivered through virtual delivery; and
7. It is important for the provider and the beneficiary to be in a quiet, private space that is free of distractions during the session.

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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 session 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-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 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 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 delivery of onsite day habilitation services must be on the approved POC and should be delivered as outlined in the Office of Citizens with Developmental Disabilities (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;

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2. Must utilize EVV to check in and out of virtual delivery of 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 day habilitation.

Place of Service

CLE is delivered in the community and outside of the day habilitation center and the beneficiary'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.

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.

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- 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.

Service Limits

1. Standard unit is a 15-minute increment;
2. 6,720 units are shared and may be flexed across CLE and onsite day habilitation; and
3. 1:1 CLE share the overall total number of 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. 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)	At 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 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. The staff providing transportation cannot also be providing another service at the same time as providing transportation; and
9. Transportation is not billable for virtual delivery of onsite day habilitation.

Provider Qualifications

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

1. Be licensed as an ADC provider by the LDH with a provider type 14; and
2. Meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements, and other 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

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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 have been 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 career 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;
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;

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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 beneficiaries' 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 what 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 guidelines of the United States Fair Labor Standards Act of 1938 as amended.

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.

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Under the service umbrella of ‘Prevocational’, there are 2 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 on-going to ensure that the beneficiary is receiving the supports they need and to develop the profile to assist in going to work.

The 2 services available under the overarching service title of Prevocational Services 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 used 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 interest, skills, and general information about each beneficiary that will assist in developing a path to employment in the community. Based off the person-centered planning, activities should be tailored for each beneficiary in preparing 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.

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;

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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 does not allow the beneficiary to attend in person (i.e. medical issues/surgery), an emergency, or when the beneficiary chooses not to 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, such as in-home supports. 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 as this is an individual choice to participate in this delivery method or not.

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 provider will include a discussion about virtual delivery with each beneficiary and 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:

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

Providers will receive written instructions on the delivery of virtual services based on their 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 emergency room (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 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;
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 session 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

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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, but will allow for the beneficiary to not miss out on 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.

The outcome of all prevocational services, is that the beneficiary will pursue individual community employment. These services are time limited to 4 years, however the goal should be to complete the services. The beneficiary should be within one year of wanting to find 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.

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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 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 received 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. 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	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. The use of the EVV system is not mandatory for this service; however, **transportation must be entered into 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. The staff providing transportation cannot also be providing another service at the same time as providing transportation; 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 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 if applicable.

This service is typically for beneficiaries 18 years and older and 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 71), as well as any applicable provisions under the State Plan.

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Service Limits

1. Standard unit of service is a 15 minute increment;
2. 6,720 units are allowed per POC year;
3. Total units are shared and flexed across CCP 1:2-4 and Onsite PV 1:5-8; and
4. CCP 1:1 shares the total units but the service is listed separate on the POC, as it is not 'flexed' with CCP 1:2-4 or Onsite PV 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 certificate of completion from an approved program and;
2. Maintain this certificate by completing 15 hours of employment related training annually and provide documentation to the local 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 other 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 local 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 other HCBS guidance as provided.

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Respite

Respite is a service provided on a short-term basis to a beneficiary unable to care for themselves because of the absence of or need for relief of those unpaid caregivers/persons normally providing care for the beneficiary. Services may be provided in the beneficiary's home/private residence or in a licensed respite care facility determined appropriate by the beneficiary or responsible party.

Respite services may be preplanned on the POC; however, if a beneficiary anticipates needing respite in the POC year, but does not know when this will occur, they and their responsible party should receive a Freedom of Choice (FOC) list of respite providers and interview these providers.

In this manner, the beneficiary and their responsible party(ies) and the provider chosen will be familiar with each other. When a situation occurs during the POC year in which respite will be needed, a revision to the POC will be done by the support coordinator and the beneficiary will be able to access the service in a timely manner.

Restrictions with Other Services

Beneficiaries receiving respite may use this service in conjunction with other SW services as long as services are not provided during the same period in a day.

Service Limits

1. A standard unit of service is a 15 minute increment; and
2. 428 units are allowed per POC year.

Provider Qualifications

Respite service providers must meet the following requirements:

1. Be licensed as a center-based respite care service provider by LDH; and/or
2. Be a licensed personal care attendant (PCA) service provider by LDH; and
3. Meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Setting Rule requirements, and other HCBS guidance as provided.

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Habilitation

Habilitation services are designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and/or in community settings.

These services are designed to assist the beneficiary in becoming more independent in their home and community, and assisting the beneficiary in creating their meaningful day. Goals may cover a wide range of opportunities such as learning how to clean house, do laundry, wash dishes, grocery shop, bank, cook meals, shop for clothing and personal items, as well as, become involved in community recreational and leisure activities, do personal yard work, and use transportation to access community resources. Goals should be incorporated into the POC.

Habilitation services include, but are not limited to, the following:

1. Participation in activities in the community to enhance their social skills;
2. Learning how to make choices about their day. For example, going to a restaurant, making choices about what they want to order and learning to place their order;
3. Learning to use the bus system or other public transportation sources and while also learning how to get about in their community including getting to their own individual job;
4. Participation in clubs or organizations that are related to their hobbies, sports or other areas of interest, such as political or civic events and learns how to be a contributing member of their community;
5. Assistance in learning how to maintain their home by washing dishes, laundry, vacuuming, mopping and other household tasks;
6. Acquiring skills needed to cook/prepare nutritional meals in their home;
7. Assistance in learning how to grocery shop in the community as well as other community activities such as going to the bank, library and other places in the community;
8. Assistance and prompting with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs,

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and any medical task that can be delegated. However, personal care assistance may not comprise the entirety of this service; and

9. Learning how to observe basic personal safety skills in the community.

Habilitation services may be provided at any time of day or night on any day of the week, as needed by the beneficiary, to achieve a specified goal.

Beneficiaries receiving habilitation services are reasonably expected to independently achieve the goal(s) identified on their POC. The goals should be consistent with the beneficiary's desires and preferences and revised as needed throughout the POC year.

Place of Service

Habilitation services are provided in the home or community with the beneficiary's place of residence as the primary setting, and include the necessary transportation.

Staffing Ratio

Habilitation services may **only** be provided on a one staff to one (1:1) beneficiary ratio.

Family members who provide habilitation services must meet the same standards as providers who are unrelated to the beneficiary and must be employed by a provider agency. Service hours shall be capped at 40 hours per week/per staff, Sunday to Saturday, for services delivered by family members living in the home. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide habilitation services for a beneficiary following the requirements outlined in the family as a paid caregiver.

Restrictions with Other Services

Beneficiaries receiving habilitation may use this service in conjunction with other SW services as long as services are not provided during the same time period in a day with the exception of CLED, as the beneficiary does not have to be present for this service.

Service Limits

1. A standard unit of service is a 15 minute increment; and
2. 285 units are allowed per POC year.

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Provider Qualifications

Providers of habilitation services must meet the following 2 requirements:

1. Be licensed by the LDH as one of the following service providers:
 - a. Center-based respite care;
 - b. PCA;
 - c. Occupational therapist (OT) in Louisiana;
 - d. PT in Louisiana;
 - e. Therapeutic recreation as a therapeutic recreational specialist; or
 - f. Licensed ADC - provider type 14.

AND

2. 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.

Housing Stabilization Transition Services

Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing (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:
 - a. Access to housing;
 - b. Meeting the terms of a lease;
 - c. Eviction prevention;

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- 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 with viewing and securing housing as needed. This may include:
 - a. Arranging or providing transportation;
 - b. Assisting in securing supporting documentation/records;
 - c. Assisting with completing/submitting applications;
 - d. Assisting in securing deposits; and
 - e. Assisting with 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; and
 - c. Identifies where other provider(s) or services may be required to meet the goal.
- 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 PSH is unavailable to support completion of 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 OCDD state 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.

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Housing Stabilization Services

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

1. Conducting a housing assessment that identifies the beneficiary's preferences related to housing (type and location of housing, living alone or with someone else, accommodations needed, and other supportive 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 support plan;
3. Developing an individualized housing stabilization service provider plan based upon each assessment that:
 - a. Includes short and long-term measurable goals for each issue;
 - b. Establishes the beneficiary's approach to meeting the goal; and

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- c. Identifies where other provider(s) or service may be required to meet the goal.
- 4. Providing supports and interventions according to the individualized housing support plan. If additional supports or services are identified as needed outside the scope of housing stabilization service, the needs must be communicated to the support coordinator;
- 5. Updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status; and
- 6. Providing ongoing communication with the landlord or property manager regarding:
 - a. Beneficiary's disability;
 - b. Accommodations needed; and
 - c. Components of emergency procedures involving the landlord or property manager.

If at any time the beneficiary's housing is placed at risk (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 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 or housing stabilization services (see definition) can be used per POC year without written approval from the OCDD state office.

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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

Payments will not be authorized until the OCDD state office gives final POC approval.

OCDD state office reviews all documents to ensure all requirements are met. If all requirements are met, the LGE approves the POC and authorizes the payment.

The PSH provider is notified of the release of the prior authorization (PA) and can bill the Medicaid FI for services provided.

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

Personal Emergency Response Systems

A PERS is a rented electronic device that enables beneficiaries to secure help in an emergency.

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

Service Limits

Coverage of the PERS is limited to the rental of the electronic device. The monthly rental fee, regardless of the number of units in the household, must include the cost of maintenance and training the beneficiary on how to use the equipment.

Reimbursement will be made for a one-time installation fee for the PERS unit.

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Agency Provider Type

Providers must be enrolled as a Medicaid Home and Community-Based Services (HCBS) Waiver service provider of PERS. The provider shall install and support PERS equipment in compliance with all applicable federal, state, parish and local laws, and meet manufacturer's specifications, response requirements, maintenance records, and beneficiary education requirements.

Support Coordination

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

At a minimum, support coordinators are required to make the following contacts with each beneficiary:

1. Monthly telephone phone calls; and
2. Quarterly face-to-face visits.

At a minimum, all initial and annual POC meetings and one additional visit must be delivered face-to-face in the beneficiary's home during each POC year. If a beneficiary participates in day service and/or employment service, the support coordinator should observe the beneficiary in the environment during at least one of the quarterly face-to-face visits. The 2 additional required face-to-face visits may be delivered virtually if agreed upon by the beneficiary and/or legal guardian and all of the requirements necessary for virtual visits are met.

SC activities include, but are not limited to, the following:

1. Convening and facilitating the person-centered planning team meetings that the beneficiary runs, which include whomever the beneficiary chooses to invite. Examples include: the beneficiary, beneficiary's family, direct service providers, 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. Offering FOC of providers that include non-disability specific settings;

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3. Ongoing coordination and monitoring of supports and services included in the beneficiary's approved POC;
4. Ongoing discussions with the beneficiary about employment including identifying barriers to employment and working to overcome those barriers, connecting the beneficiary to CWIC to do benefits planning, referring the beneficiary to LRS and following the case through closure with LRS, and other activities of the employment process as identified. This includes the quarterly completion of and data input using the Path to Employment form;
5. Building and implementing the supports and services as described in the POC;
6. 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;
7. 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;
8. Assisting with problem solving with the beneficiary, supports, and services providers;
9. 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;
10. Advocacy 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;
11. 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);
12. Oversight of the service providers to ensure that their beneficiary receives appropriate services and outcomes as designated in the POC;

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13. Assisting the beneficiary to overcome obstacles, recognize potential opportunities and developing creative opportunities;
14. Meeting with the beneficiary in face-to-face meetings as well as phone contact as specified. This includes meeting them where the services take place;
15. Reporting and documenting any incidents/complaints/abuse/neglect according to the OCDD policy;
16. Arranging any necessary professional/clinical evaluations needed and ensure beneficiary choice;
17. 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;
18. Preparing the annual social summary; and
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.

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

Service Limits

SC shall not exceed **12** units in a POC year. A standard unit of service for SC is one month.

Provider Qualifications

SC providers must meet the following requirements:

1. Be licensed as a SC provider; and
2. Meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, HCBS Settings Rule requirements, and other HCBS guidance as provided.

NOTE: Refer to SW Section 43.8, Support Coordination, for additional guidance.

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Expanded Dental Services for Adult Waiver Beneficiaries

Refer to the Dental Benefit Program Manager Manual:

https://ldh.la.gov/assets/medicaid/DBPMP/DBPM_Manual_2022-04-01.pdf

Specialized Medical Equipment

This service is for the delivery of incontinence supplies and related items as outlined in the Incontinence Product Manual and itemized list. This service is for beneficiaries, ages 21 and older, who require the use of incontinence supplies and related supplies. Supports provided through this service will allow the beneficiary to remain engaged in community related activities.

This service is intended to be a supplement for incontinence supplies and is not intended to supply the entire need for this service.

Beneficiaries, ages 20 and younger, will receive their incontinence supplies through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

For additional information, please refer to the OCDD Incontinence Products Manual.

Requirements

1. Beneficiary must be at least 21 years old to receive incontinence supplies; and
2. Beneficiary must have a physician's order and updated annually for incontinence supplies.

Service Limits

Incontinence supplies are capped at \$2,500 per POC year per beneficiary.

If the beneficiary requires additional incontinence supplies beyond the \$2,500 limit, the support coordinator will assist the beneficiary in obtaining the supplies needed through other funding sources.

Provider Qualifications

Incontinence product providers must meet the following requirements:

1. Be licensed as an assistive devices provider (provider type 17) by the LDH; and

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2. Meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*, 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 increase membership in their community. The connections should reflect the beneficiary’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 service. Proficiency in person-first language is essential for effective interaction with all stakeholders. The person should be well versed in person-first language and can effectively communicate with people.

The goal of CLED is to increase community connections and memberships that reflects the beneficiary’s interest and choices.

Place of Service

This service is provided 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 provided concurrently on the same day as day habilitation, prevocational, and or SE services, provided that day habilitation is included in the beneficiary's POC.

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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 forwarded to both 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).

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:

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

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PROGRAM MONITORING

Services offered through Supports Waiver (SW) are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal regulations.

Health Standards Section (HSS) staff or its designee conducts on-site reviews of the Home and Community-Based Waiver (HCBS) provider agencies who are licensed through this agency. 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.

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. 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 (SC) agency, and direct service providers and other employees of the direct service provider 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 Electronic 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;

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4. Knowledge;
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; and
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.

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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 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 (OAG) to investigate Medicaid fraud. The

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Office of the Inspector General (OIG), Federal Bureau of Investigation (FBI), and postal inspectors also conduct investigations of Medicaid fraud.

Quality Management

Direct service providers and SC 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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INCIDENTS, ACCIDENTS AND COMPLAINTS

The support coordination (SC) agency and direct service provider are responsible for ensuring the health and safety of the beneficiary. SC 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. (See Appendix C for Contact Information).

If the beneficiary needs emergency assistance, the worker must 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.

SC agencies and direct service providers 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).

Internal Complaint Policy

Beneficiaries must be able to file a complaint regarding their services without fear of reprisal. The provider must have a written policy to handle beneficiary complaints. In order to ensure that the complaints are efficiently handled, the provider must comply with the following procedures:

1. Each provider must designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator must maintain a log of all complaints received. The complaint log must include:
 - a. The date the complaint was made;
 - b. Name and telephone number of the complainant; and

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- c. Nature of the complaint and resolution of the complaint;
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 must 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 must 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 authorized 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 OCDD 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

La. R.S. 40:2009.13 - .21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the Home and Community-Based Services (HCBS) waiver programs. When the substance of the complaint is furnished to the service provider, it must 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 must be given the opportunity to withdraw the complaint.

The OCDD may determine when the complaint is initiated that a disclosure statement is necessary.

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If a Complainant Disclosure Statement is necessary, the complainant must be contacted and given an opportunity to withdraw the complaint.

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 Central 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 consumer or consumers. (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 consumer's activities of daily living. (La. R.S. 40:2009.14);
3. **Trivial report** - is an account of an allegation that an incident has occurred to a beneficiary or beneficiaries that causes no physical or emotional harm and has no potential for causing harm to the beneficiary or beneficiaries. (La. R.S. 40:2009.14);
4. **Allegation of noncompliance** - is an accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers. (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 wellbeing 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 persons or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 14:403.2);
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.

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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 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 is not competent 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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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;

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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;
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 program, a provider must:

1. Meet all of the requirements for licensure as established by applicable state laws and rules promulgated by the Louisiana Department of Health (LDH);
2. Agree to abide by all applicable rules and regulations established by the Centers for Medicare and Medicaid Services (CMS), LDH, and other state agencies;
3. Comply with all the terms and conditions for Medicaid enrollment; and
4. Follow the expectations of the HCBS Settings Rule, issued March 17, 2014 (42 CFR § 441.530 - Home and Community-Based Setting).

It is the provider's responsibility to ensure annual compliance with the HCBS Settings Rule through signing an attestation form. Providers must 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 completed the HCBS training related to compliance with Louisiana Administrative Code (LAC) Title XXI Chapter 9. Provider Requirements for participation in the waiver programs mandate that the provider has been issued a Medicaid provider number.

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Providers must participate in the initial trainings for prior authorization (PA) and data collection, as well as 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.

Providers must have available computer equipment, software, and internet connectivity necessary to participate in trainings, PA, data collection, and electronic visit verification (EVV).

It is the provider's responsibility to ensure that the use of contractors, including the use of independent contractors, complies with all state and federal laws, rules and/or regulations, including those regarding LAC Title XXI Chapter 9: Provider Requirements and those enforced by the United States Department of Labor.

All residential providers must maintain a toll-free telephone line with 24-hour accessibility manned by either a staff member or an answering service. This toll-free number must be given to beneficiaries at either intake or 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.

Providers must develop a Quality Improvement and Self-Assessment Plan. This document completed by the provider describe the procedures used and the evidence presented to demonstrate compliance with program requirements. The first self-assessment is required 6 months after approval of the Quality Improvement Plan (QIP), and must be carried out annually thereafter.

The QIP must be submitted for approval within 60 days after LDH provides the training.

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 in Louisiana Medicaid 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 also must not have an outstanding Medicaid program audit exception or other unresolved financial liability owed to the state.

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Changes in the following areas are to be reported in writing to LDH, Health Standards Section (HSS), to OCDD, and to the fiscal intermediary's (FI) Provider Enrollment Section in 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).

The provider must complete a new provider enrollment packet when a change in ownership of 5 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. Beneficiaries should be offered a new FOC when this occurs.

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

Providers may not refuse to serve any waiver beneficiary who 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 remains no option but to refuse services. Such refusal to serve an individual must be made 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 agency.

The beneficiary's provider and support coordination (SC) 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, which includes all providers who are providing a service on the POC;

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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.

The Supports Waiver (SW) 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
Support Coordination	<p>Case Management License Providers of SC for the SW program must have a signed performance agreement with OCDD to provide services to waiver beneficiaries.</p> <p>SC agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined in the Case Management Services manual chapter, LAC Title XXI, and the SW Provider Manual.</p>	Provider Type 45 Case Management
Center-Based Respite	HCBS Provider License Respite Care Module for a facility	Provider Type 83: Respite
In-Home Respite	N/A	Provider Type 82: Attendant Care Services
Personal Emergency Response Systems (PERS)	Must meet all applicable vendor requirements, federal, state, parish and local laws for installation.	Provider Type 16: PERS
Habilitation	HCBS Provider License	Provider Type 82, 98, 14 or 13
Dental	Current and valid Louisiana license to practice in the field of expertise/specialty	Provider 27: Dental-Individual or Group

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Waiver Service	Requirements	Service Provided by
Specialized Medical Equipment	Must meet all applicable vendor standards and requirements for manufacturing, design, and installation of technological equipment and supplies.	Provider Type 17: Assistive Devices
Individual Supported Employment	Employment Specialist has a certification from an approved vendor in a 40 hour supported employment program with 15 hours of employment related training annually or be a current cardiopulmonary resuscitation (CRP) with Louisiana Rehabilitation Services	Provider Type 98: Individual Supported Employment
Group Supported Employment	Employment specialist has a certification from an approved vendor in a 40 hour supported employment program with 15 hours of employment related training annually OR HCBS Provider license with Adult Day Care (ADC) Module or Employment specialist has a certification from an approved vendor in a 40 hour supported employment program with 15 hours of employment related training annually	Provider Type 98: Group Supported Employment
Onsite Prevocational Services/Community Career Planning	HCBS Provider License (ADC Module)	Provider Type 13: Prevocational Habilitation
Onsite Day Habilitation/Community Life Engagement	HCBS Provider License (ADC Module)	Provider Type 14: Adult Day Habilitation
Community Life Engagement Development (CLED)	HCBS Provider License (ADC Module)	Provider Type 14: Adult Day Habilitation

When required by state law, the person performing the service, must meet all applicable requirements for professional licensure.

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Provider Responsibilities for All Providers

All providers of SW services are responsible for the following:

1. Ensuring an appropriate representative from the agency attends the POC planning 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 (DSW) 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 plan of care documents/attachments are updated and kept current as changes occur, including the beneficiary's emergency contact information and list of current medications;
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, and such information must be provided no 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 timelines;
7. Providing the support coordination agency or LDH representatives with requested written documentation, including, but not limited to:
 - a. Completed, signed, and dated POC attachment;

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- b. Service logs, progress notes, and progress summaries;
 - c. 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/beneficiary's family in their native language, the beneficiary rights and responsibilities within the agency; and
9. Ensuring that beneficiaries are free to make a choice of providers without undue influence.

Note: It is the policy of the 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

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

SC activities include, but are not limited to, the following:

1. Assisting the beneficiary in coordinating and convening the person-centered planning team for the annual POC and/or as needed. Supporting the beneficiary to lead the meeting, which should include those who the beneficiary chooses to participate in the meeting. Those might include, but are not limited to, the beneficiary's family, friends, direct service provider(s), including the day and/or employment provider, employer (if applicable), medical and social work

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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. Support coordinator should participate in training regarding employment and assisting the beneficiary with obtaining employment;
3. Complete a quarterly discussion around employment and the career path with each beneficiary who wants to work;
4. Offer FOC of providers and settings, to include non-disability specific settings to each beneficiary;
5. On-going coordination and monitoring of supports and services included in the beneficiary's approved POC;
6. Building and implementing the supports and services as described in the POC;
7. 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;
8. 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;
9. Assisting with coordinating transportation so that the beneficiary may have access to medical services, community resources and their job;
10. Assisting the beneficiary, families, services providers, and/or the LGE with the problem solving;
11. 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;
12. 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

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and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;

13. 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);
14. Oversight of the service providers to ensure that the beneficiary receives appropriate services and outcomes as designated in the POC;
15. Assisting the beneficiary to overcome obstacles, recognize potential opportunities, and develop creative opportunities;
16. 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. The initial and annual POC meetings are to be done in a face-to-face meeting, preferably in the home, and at least one other meeting during the POC year must be done in a face-to-face manner;
17. Make the determination, using the guidelines provided, to determine if the beneficiary meets the criteria for virtual visits. If the criteria is met, the additional 2 meetings may be completed virtually, using an allowed source. The meeting may not be conducted telephonically and must be done where the individual and the home may be observed;
18. Reporting and documenting any incidents, complaints, abuse, and/or neglect according to the OCDD policy and in accordance with licensure, state laws, rules, and regulations, as applicable;
19. Arranging any necessary professional/clinical evaluations needed and ensuring beneficiary choice;
20. 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;
21. 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

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22. On-going discussions with the beneficiary, if they are of working age, 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. Assisting the beneficiary in the reporting of income to social security;
 - c. Assisting the beneficiary in setting up an Achieving a Better Life Experience (ABLE) account;
 - d. Referring the beneficiary to Louisiana Rehabilitation Services (LRS);
 - e. Following the case through closure with LRS; and
 - f. Other activities in the employment process may be 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.

Support Coordination Providers Qualifications

SC providers must meet the following requirements:

- 1. Must be licensed as a SC 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 SC Reference Guide for additional information.

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Provider Responsibilities for All Residential Care Service Providers

Direct service provider agencies must have written policy and procedure manuals that include, but are not limited to, provisions that govern the following:

1. Training policy that includes orientation and staff training requirements according to the 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 in order to adequately perform care and assistance as required by waiver beneficiaries;
3. Employment and personnel job descriptions, hiring practices that include 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/beneficiary's 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: requirement for proper use of check in/out; acceptable editing of electronically captured services; reporting services when in "no service zones" or failure to clock 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;

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10. Criminal history checks: requirement for compliance with state statutes for non-licensed direct care personnel; and
11. DSW Wage floor: requirement for provider agencies to follow the DSW Wage floor established by Louisiana Medicaid and pay the DSWs as directed. The current wage floor can be found in the LAC and OCDD will post a memo on their website (<https://ldh.la.gov/subhome/11>) and providers will be responsible for following this directive.

POC Provider Documents

The direct service provider must complete the provider attachments that are a part 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 direct service provider 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

Direct service providers 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 includes during times when the scheduled DSW is absent or is unavailable or unable to work for any reason.

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All direct service providers 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.

Direct service providers are required to:

1. Have policies in place that outline the protocols that the agency has established to ensure 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 a minimum, on an annual basis to ensure 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.

Direct service providers 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 back-up, but this does not exempt the provider from the requirement of providing the necessary staff for back-up 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 direct service provider will respond to potential emergency situations such as fires, hurricanes, tropical storms, hazardous material release, flash flooding, ice storms, and terrorist attacks.

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

1. Individualized risk assessment of potential health emergencies;
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, SC agencies, and direct service provider 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 of this manual chapter for website information).

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Day Habilitation Provider Responsibilities

The providers who provide Day Habilitation services must possess a current, valid HCBS Provider ADC License to provide day habilitation/community life engagement (CLE) services and must adhere to 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 valid, current Louisiana driver's license that is applicable to the vehicle being used;
3. 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; and

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 SC.

4. Vehicles used in transporting beneficiaries must:
 - a. Be in good condition and repair;
 - b. Have a current Louisiana inspection sticker; and
 - c. Have a first aid kit on board.

Supported Employment Provider Responsibilities

Supported Employment (SE) 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 Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) [20 U.S.C. 1401 (26) and (29.)], if available. LRS does not fund group employment, only individual employment. Therefore, if an individual is seeking group employment, this does not apply.

The employment specialist must possess a current certification from an accepted SE training program and the continuing education hours required (20 every two years). The provider may also

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have a valid HCBS Provider ADC license, but this is not a requirement to provide SE services in the community.

SE providers who have an ADC license must adhere to 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 valid, current Louisiana driver's license applicable to the vehicle being used;
3. 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; and

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 SC.

4. Vehicles used in transporting beneficiaries must:
 - a. Be in good condition and repair;
 - b. Have a current Louisiana inspection sticker; and
 - c. Have a first aid kit on board.

Providers must have a documented quarterly discussion with individuals who are working in group employment or individual employment.

The discussion should include the following:

1. Is the individual happy with the current job?
2. Is the individual interested in additional hours or advancement on the job?

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In addition to these questions, if the individual is working in group employment:

1. Is the individual interested in finding individual employment in the community?
2. Is the individual interested in career planning services?
3. Is the individual interested in additional hours or advancement?

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 Section 602 (16) and (17) of the IDEA [20 U.S.C. 1401 (26) and (29)], if available.

The service provider must adhere to 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 valid, current Louisiana driver's license that is applicable to the vehicle being used;
3. The provider must document this service in the beneficiary's record, and the trip must be documented in the provider's transportation log; and
4. The vehicles used in transporting beneficiaries must:
 - a. Be in good condition and repair;
 - b. Have a current Louisiana inspection sticker; and
 - c. Have a first aid kit on board.

Providers should review the progress made on the Individual Career Planning Profile on a quarterly basis. The provider must have a documented quarterly discussion with individuals who are in this service to include the following:

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1. Review of the Individual Career Planning Profile and the progress made thus far;
2. Is the individual still interested in finding employment;
3. Potential employment opportunities in the community; and
4. Ensure the individual is still interested in career planning services.

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SUPPORT COORDINATION

Support coordination (SC), which is also referred to as case management, is a waiver service that is provided to all Supports Waiver (SW) beneficiaries. SC 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 (SCAs) 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

Intake serves as an entry point into the Waiver and is used to gather baseline information to determine the beneficiary's medical eligibility for waiver services, service needs, appropriateness for services, including SC.

Intake Procedures

Referrals for SC services are only made from the Office for Citizens with Developmental Disabilities (OCDD) through the Medicaid data management contractor. The applicant must be interviewed to obtain the required information regarding their demographics, preferably through a face-to-face interview in the applicant's home, within three working days of receipt of the Freedom

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of Choice (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 local governing entity (LGE) will transfer the eligibility documents along with the transfer of records to the SCA. 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 SC intervention; and
2. Is receiving SC service or other services from another provider or community resource.

NOTE: If the applicant is receiving SC 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 SC from another provider must remain with their current provider until approved for the waiver. Requests to change to a different SCA may be made following waiver certification. Refer to the "Changing Support Coordination Agencies" subsection 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;

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4. Accepted SC service;
5. Was advised of the right to change SC providers, support coordinators, and/or service providers; and
6. Was advised that waiver services and SC service are an alternative to institutionalization.

If SW services 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, or begin the process for moving to the Residential Options Waiver (ROW) using the tiered waiver process.

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 SC service by defining the beneficiary's needs and assisting in the development of the POC.

Assessment Process

The support coordinator must conduct the person-centered support assessment which consists 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.

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Characteristics and components of the assessment include:

1. Identifying information (demographics);
2. Use of a standardized instrument for certain targeted populations;
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 information;
11. Employment discussion that includes past and present employment, or if the person has never worked a discussion about looking for employment, including benefits planning and how employment can improve their life;
12. Daily activities, including how they spend their time and in what hobbies they participate (e.g., church, clubs, volunteering, ect.);
13. Housing/physical environment of the beneficiary;
14. Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes;
15. Information relevant to understanding the supports and services needed by the beneficiary to achieve the desired personal outcomes, (e.g., input from

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formal and informal service providers and caregivers as relevant to the personal outcomes); and

16. 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 authorized representative to secure appropriate services. A signed authorization for release of information must be obtained and filed in the case record.

NOTE: Evaluations, tests, and/or reports are not covered SC 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 of 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

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who the beneficiary chooses to participate in the process. This may include family, friends or other support systems, the support coordinator, appropriate professionals/service providers, and others who best know the beneficiary.

The purpose of the POC is 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
3. Represent a strategy for ensuring that services received are the choice of the beneficiary, are appropriate and available, and are responsive to the beneficiary's changing outcomes, desires, and 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 at a time that is convenient for the beneficiary. The initial and annual POC must include the beneficiary and the service provider, and may include members of the support network; the support network, may include family members, appropriate professionals, persons, who are well acquainted with the beneficiary, and who the beneficiary chooses to invite.

The POC must:

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1. Be outcome-oriented, individualized and updated on at least an annual basis. The planning process should include tailoring the POC to the beneficiary's needs and desires based on the on-going 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, and appropriate professional personnel must be directly involved in the development of the POC;
2. Assist the beneficiary in making informed choices, including the choice to receive services in a non-disability specific setting, and regarding all aspects of supports and services needed to achieve their desired personal outcomes. This 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;
3. Incorporate steps that empower and help the beneficiary to develop independence, growth, and self-management; and
4. Be written in a 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.

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. Beneficiary's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing foremost on informal natural/community supports and if needed, paid formal services;
2. Budget payment mechanism, as applicable;

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3. Target/resolution dates for the achievement/maintenance of personal outcomes;
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 six-month 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 management contractor. A change in direct service providers 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.

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;

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2. Assisting the beneficiary/beneficiary's 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/beneficiary's family on potential community resources, including formal resources (Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), housing, Medicaid, benefits planning, Louisiana Rehabilitation Services (LRS), 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 service 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;
9. Assisting the beneficiary to overcome obstacles, recognize potential opportunities, and develop creative opportunities;
10. Monthly phone calls with the beneficiary; and

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11. Meeting with the beneficiary face-to-face in the beneficiary's home, for each initial and/or annual POC development, and for at least one other quarterly meeting. These quarterly meetings may happen on a more frequent basis if so requested by the beneficiary/beneficiary's family and that such meetings can be completed in the day program. If the beneficiary meets the criteria for virtual visits and requests a virtual visit, the remaining two 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:**
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 management contractor. All incomplete packages will be returned.
2. **Revisions to the POC:**
Revisions must be submitted 10 working days prior to the change.
3. **Emergencies:**
Emergency changes must be submitted within 24 hours or the next working day following the change.
4. **Reviews:**
 - a. At a minimum, the POC should be reviewed on a quarterly basis to ensure that the personal outcomes and support strategies are consistent with the needs and desires of the beneficiary; and
 - b. At a minimum, the POC must be revised on an annual basis or as otherwise needed, but in no case shall it be revised later than 35 days prior to expiration. The POC may be submitted as early as 60 days prior to expiration, provided the form 90-L does not expire prior to the POC expiration date.

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Changes in the Plan of Care

If there are significant changes to the POC (i.e., adding or deleting services) in the way that the beneficiary prioritizes their personal outcomes, and/or if there are significant changes to 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. Whenever possible, additional service needs should be anticipated and planned for in the initial/annual POC during the POC meeting. When an unidentified need is identified 10 or more business days prior to the change, a POC Revision request should be submitted and will be processed within 10 business days. The revision should be marked as “routine”. If an unanticipated need is identified less than 10 business days prior to the needed change, the POC revision request must be identified as “urgent” and the additional responsibilities for the Provider and support coordinator must be assumed. For “urgent” requests, the box must be checked. An urgent need exists when there is an unplanned/unpredictable event which requires urgent changes to waiver services and/or changes in the service provider. Urgent changes are defined as changes that must begin in fewer than 10 business days off receipt by the LGE.

Initiating a Change in the Plan of Care

The beneficiary/beneficiary’s family will contact the support coordinator when a change is required. The support coordinator will call a meeting with the service provider(s) to complete the POC revision form. All participants attending the meeting 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

A copy of the approved POC must be kept at the beneficiary’s home, in the beneficiary’s case record at the SCA, 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

POC monitoring should be completed monthly, quarterly and annually using the SC

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Documentation form.

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 do not need to be duplicated in the case record.

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/Working Plan of Care

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 'working' 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 that the POC is unsatisfactory or is inadequate in meeting the beneficiary's service needs.

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Annual Reassessment

A completed annual reassessment package must be received by the LGE no later than **35 calendar days**, but as early as **60 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.

SCA Approval Authority of SW Annual Plan of Care

Support coordinators have limited POC approval authority as authorized by OCDD. Approval of a POC for an annual reassessment shall be limited to those cases where:

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.

Transition/Closure

The transition or closure of SC services must occur in response to the request of the beneficiary or when it is determined that the beneficiary is no longer eligible for services. The closure process must ease the transition to other services or care systems outside of waiver.

Closure Criteria

Criteria for closure of waiver and SC 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 SC.

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. As part of the transition/closure procedure, support coordinators must:

1. Notify the beneficiary/beneficiary's family immediately if the beneficiary becomes ineligible for services;
2. Complete a final written reassessment identifying any unresolved problems or needs and discuss methods of negotiating their own service needs with the beneficiary;
3. Notify the service provider(s) 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).

As part of the transition/closure procedure, the SCA must:

1. Notify the LGE of the transition/closure four weeks prior to the closure to allow the LGE 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

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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.

NOTE: An agency shall not close a beneficiary's case when there is a pending appeal. The case may be closed only upon receipt of the appeal decisions. If an appeal is requested within 10 days, the case remains open. If an appeal is 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 SC services.

Changing Support Coordination Agencies

When a beneficiary selects a new SC provider, the data management contractor will link the beneficiary to the new provider. The new SC provider must:

1. Complete the FOC file transfer;
2. Obtain the case record and authorized signature; and
3. Inform the transferring SCA.

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 SC provider shall continue to provide services until the records are transferred to the receiving provider and the transferring provider is eligible to bill for SC services after the dated

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SECTION 43.8: SUPPORT COORDINATION

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notification is received (transfer of records) by the receiving agency. In the month the transfer occurs, the receiving agency shall begin providing services within three 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 and Medicaid data management contractor to begin PA immediately after the transfer of records.

Other Support Coordination Responsibilities**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, 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 43.6 – Incidents, Accidents and Complaints of this manual chapter for additional instructions.

DEVELOPMENTAL DISABILITY LAW

A developmental disability is defined by the Developmental Disability Law (Revised Statutes 28.452.1). 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 22;
 - 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; or
 - 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, 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 9 which, without services and support, has a high

probability of resulting in criteria that, later in life, may be considered to be a developmental disability.

CHAPTER 43: SUPPORTS WAIVER**APPENDIX B: SERVICE PROCEDURE CODES/RATES****PAGE(S) 5**

The following chart describes the codes and rates that are to be used with the Supports Waiver (SW). Providers must bill the appropriate procedure code for the service performed.

PROVIDER TYPE	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER	SECOND MODIFIER	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
98	Work Based Learning Experience	H2023	UK	U1	\$175.00	Per Assessment	3
98	Group Employment Job Assessment, Discovery, and Development	H2023			\$3.78	15 minutes	480
98	Job Development/Job Placement	H2023	U1		\$20.00	15 minutes	480 units
98	Initial Job Support and Job Stabilization	H2023	TS	U1	\$18.50	15 minutes	1,920
98	Extended On The Job Supports	H2023	TT	U1	\$15.00	15 minutes	2,500
98	Follow Along Job Supports	H2023	U1		\$70.00	Per Diem	48
98	Virtual Delivery of Follow Along Job Supports	H2023	GT	U1	\$13.63		240
98	Group Employment (1:2 Beneficiary ratio)	H2025	TT		\$4.16	15 minutes	6720 shared for all H2025 codes
98	Group Employment (1:3-4 Beneficiary ratio)	H2025	UQ		\$3.50	15 minutes	6720 shared for all H2025 codes
98	Group Employment (1:5-8 Beneficiary ratio)	H2025	NO MOD		\$2.76	15 minutes	6720 shared for all H2025 codes
14	Community Life Engagement Day Habilitation (1:1 Beneficiary ratio)	T2021	TT		\$4.75	15 minutes	6720 shared for all T2021 codes
14	Community Life Engagement Day Habilitation (1:2-4 Beneficiary ratio)	T2021	UQ		\$4.00	15 minutes	6720 shared for all T2021 codes
14	Day Habilitation Onsite (1:5-8 Beneficiary ratio)	T2021	NO MOD		\$2.48	15 minutes	6720 shared for all T2021 codes

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APPENDIX B: SERVICE PROCEDURE CODES/RATES

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PROVIDER TYPE	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER	SECOND MODIFIER	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
14	Virtual Delivery of Day Habilitation (1:5-8 Beneficiary ratio)	T2021	GT		\$2.98	15 minutes	6720 shared for all T2021 codes
14	Community Life Engagement Development (1:1 Beneficiary ratio)	T2025	U1		\$7.00	15 minutes	240 shared among all T2025 codes
14	Community Life Engagement Development (1:2 Beneficiary ratio)	T2025	UN		\$4.00	15 minutes	240 shared among all T2025 codes
14	Community Life Engagement Development (1:3 Beneficiary ratio)	T2025	UP		\$3.00	15 minutes	240 shared among all T2025 codes
13	Community Career Planning (1:1 Beneficiary ratio)	H2014	TT		\$5.00	15 minutes	6720 shared for all H2014 codes
13	Community Career Planning (1:2-4 Beneficiary ratio)	H2014	UQ		\$4.50	15 minutes	6720 shared for all H2014 codes
13	Prevocational Services Onsite (1:5-8 Beneficiary ratio)	H2014	NO MOD		\$2.39	15 minutes	6720 shared for all H2014 codes
13	Virtual Delivery of Prevocational Services (1:5-8 Beneficiary ratio)	H2014	GT		\$2.98	15 minutes	6720 shared for all H2014 codes
98, 14, 13	Transportation for Supported Employment, Day Habilitation, and Prevocational on the day of delivery of service	T2002			\$20.00	Per Diem	
83	Center-Based Respite	T1005	HQ		\$4.63	15 minutes	428
82	In-Home Respite	S5125	NO MOD		\$4.63		
13, 14, 82, 98	Habilitation (1:1 Beneficiary ratio)	T2019	NO MOD		-\$4.63	15 minutes	285

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APPENDIX B: SERVICE PROCEDURE CODES/RATES

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PROVIDER TYPE	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER	SECOND MODIFIER	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
16	Personal Emergency Response System (PERS) Installation	S5160	NO MOD		\$30.00	One Time	1 in current residence and 1 each time beneficiary moves to new residence
16	Personal Emergency Response System (PERS) Monthly Maintenance	S5161	NO MOD		\$28.00	Monthly	12
45	Support Coordination	T2023	NO MOD		\$ 201.50	Monthly	12
AW	Permanent Supportive Housing Stabilization	G9012	NO MOD		\$15.11	15 minutes	93
AW	Permanent Supportive Housing Stabilization Transition	G9012	U8		\$15.11	15 minutes	72
17	Adult size brief/diaper - S	T4521			\$0.50	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Adult size brief/diaper - M	T4522			\$0.60	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Adult size brief/diaper - L	T4523			\$0.87	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Adult size brief/diaper - XL	T4524			\$0.87	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Adult size pull-on - S	T4525			\$0.85	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older

CHAPTER 43: SUPPORTS WAIVER**APPENDIX B: SERVICE PROCEDURE CODES/RATES****PAGE(S) 5**

PROVIDER TYPE	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER	SECOND MODIFIER	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
17	Adult size pull-on - M	T4526			\$0.85	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Adult size pull-on - L	T4527			\$0.94	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Adult size pull-on - XL	T4528			\$1.17	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Disposable liner/shield/pad	T4535			\$0.46	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Large disposable underpad	T4541			\$0.46	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Small disposable underpad	T4542			\$0.46	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Adult disposable brief/ diaper abv-XL	T4543			\$2.49	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Adult disposable und/pull on abv-XL	T4544			\$2.49	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Incontinence disposable penile wrap	T4545			\$1.25	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older

CHAPTER 43: SUPPORTS WAIVER**APPENDIX B: SERVICE PROCEDURE CODES/RATES****PAGE(S) 5**

PROVIDER TYPE	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER	SECOND MODIFIER	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
17	Reusable pull-on any size	T4536			\$0.76	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Reusable underpad bed size	T4537			\$8.73	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Reusable diaper/brief any size	T4539			\$2.49	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older
17	Reusable underpad chair size	T4540			\$10.00	Per item	\$2,500 Total budget for all incontinence supplies per POC for those 21 and older

CHAPTER 43: SUPPORTS WAIVER**APPENDIX C: CONTACT INFORMATION****PAGE(S) 2****CONTACT INFORMATION****Office for Citizens with Developmental Disabilities and Local Governing Entities**

Contact information for the central office and the regional local governing entities (LGEs) is found on the Office for Citizens with Developmental Disabilities (OCDD) website at:

<http://dhh.louisiana.gov/index.cfm/page/134/n/137>.

Appeals

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Louisiana Department of Health (LDH) Health Standards Section (HSS)	Office to contact to report changes that affect provider license	Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 or (225) 342-0138 Fax: (225) 342-5073
Division of Administrative Law – Health Section	Office to contact to file an appeal request	Division of Administrative Law - Health Section P. O. Box 4189 Baton Rouge, LA 70821-4189 (225) 342-5800 Fax: (225) 219-9823
Gainwell Technologies Provider Enrollment Section	Office to contact to report changes in agency ownership, address, telephone number or account information affecting electronic funds transfer	Gainwell Technologies Provider Enrollment Section P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370
Gainwell Technologies Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information	Gainwell Technologies Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or 225-924-5040
Department of Children and Family Services (DCFS) – Local Child Protection Hotline	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary under the age of 18	Refer to the DCFS website at: https://www/dcfs.louisiana.gov under the “Report Child Abuse/Neglect” link

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APPENDIX C: CONTACT INFORMATION**PAGE(S) 2**

Adult Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary aged 18-59 or an emancipated minor	Louisiana Department of Health Office of Aging and Adult Services 1-800-898-4910
Elderly Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary aged 60 or older	Governor's Office of Elderly Affairs http://goea.louisiana.gov

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APPENDIX D: FORMS AND LINKS**PAGE(S) 1**

FORMS AND LINKS

This section contains a list of the forms, handbooks and other documents that are used in the Supports Waiver (SW) program and the associated web links where the information can be obtained. Providers are required to follow the policy and procedures that are outlined for each of the documents utilized in the SW.

For additional documents and forms that may be utilized in the SW use this link:
<https://ldh.la.gov/page/4361>.

Form/Document Name	Web Address
Job Assessment, Job Discovery, and Job Development Completion Form	https://ldh.la.gov/page/4361
Rights and Responsibilities Form (Beneficiary)	https://ldh.la.gov/page/4361
Statewide Incident Management System	https://ldh.la.gov/page/137
Quality Enhancement Provider Handbook	https://ldh.la.gov/page/4361
Universal Plan of Care document and attachments	https://ldh.la.gov/page/4361
Guidelines for support planning	https://ldh.la.gov/page/4361
Bureau of Health Services Financing (BHSF) Form 90-L	http://www.ldh.la.gov/assets/docs/OCDD/waiver/NOW/90LForm0318Fillable.pdf

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. 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).

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APPENDIX E – CLAIMS FILING

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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.**

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APPENDIX E – CLAIMS FILING

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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
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.

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APPENDIX E – CLAIMS FILING

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SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#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)																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS										3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 M X F										4. INSURED'S NAME (Last Name, First Name, Middle Initial) 9876543210123																													
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)										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) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER (Specify) 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize 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 QUAL MM DD YY										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 71a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										20. OUTSIDE LAB? YES NO \$ CHARGES																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. G5 10 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION 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 C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OFF WORK H. (Print from 1-9) I. ID. QUAL. J. RENDERING PROVIDER ID. #										25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. 1234										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES 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 a. b.										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)

ISSUED: 12/11/24
REPLACED: 05/26/23

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)
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		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. RESERVED FOR NUCC USE	
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. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
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 _____	
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		17a. _____ 17b. NPI _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
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. _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	
F. \$ CHARGES		G. DAYS ON UNITS	
H. EPST Family Plan		I. ID. QUAL	
J. RENDERING PROVIDER ID. #			
25. FEDERAL TAX I.D. NUMBER SGN EIN <input type="checkbox"/> <input type="checkbox"/>			
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____	
29. AMOUNT PAID \$ _____		30. Paid 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.)			
32. SERVICE FACILITY LOCATION INFORMATION			
33. BILLING PROVIDER INFO & PH # ()			
SIGNED _____ DATE _____		a. NPI _____ b. _____	

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PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)