FAMILY SUPPORT 360 WAIVER

OVERVIEW

The Family Support 360 Waiver operated by the Division of Developmental Disabilities (DDD) provides Home and Community Based Services to children living with natural, adopted, stepfamily or relatives who act in a parental capacity, adults living independently in the community, or adults living with a family member, legal guardian, or advocate as an alternative to residing in an intermediate care facility for an individual with intellectual disabilities (ICF/IID).

ELIGIBLE PROVIDERS

Eligible Providers for Family Support 360 services must be enrolled in South Dakota Medicaid and meet any additional requirements established by DDD.

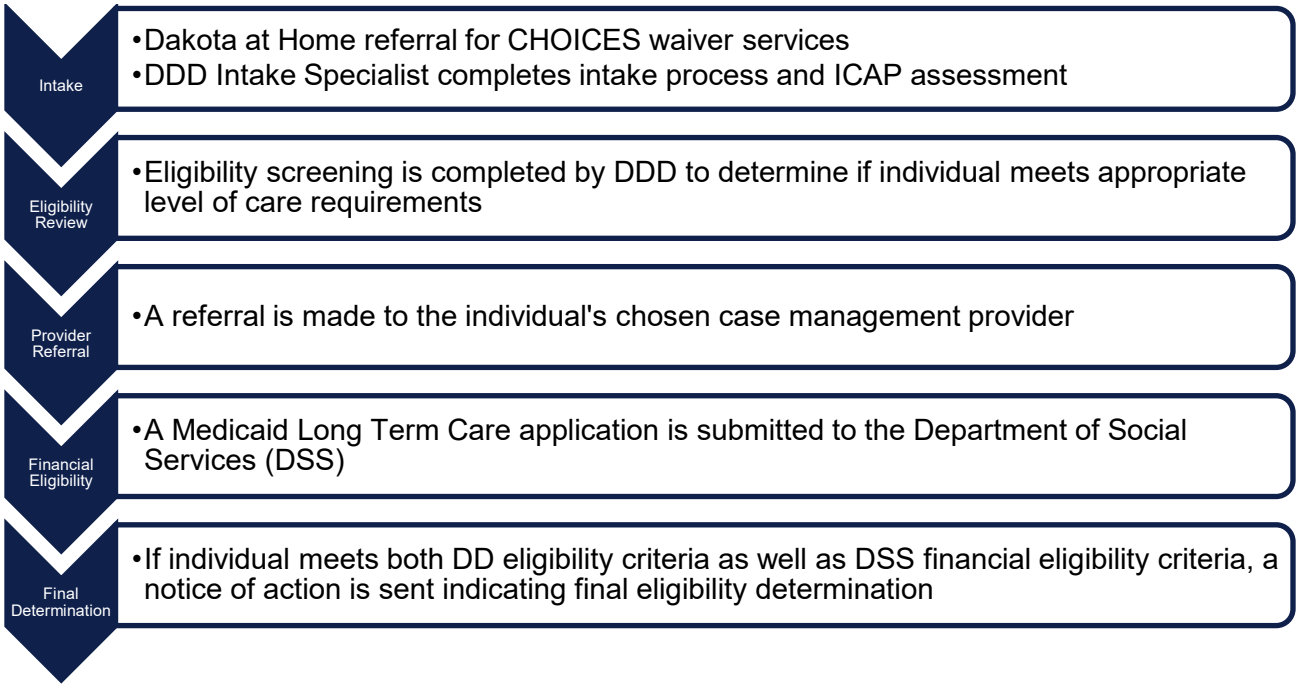
A Community Services Provider (CSP) or a Community Support Provider (SP) providing services under the Family Support 360 waiver must meet the following criteria:

- Be certified as a CSP or SP under the provisions of Administrative Rules of South Dakota (ARSD) 46:11;
- Have a signed provider agreement with the Division;
- Have a signed provider agreement with the Department of Social Services; and
- Be accredited by a national quality assurance organization, as designated by the Division.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal. To be eligible for services provided through the Family Support 360 waiver, individuals must be recipients of South Dakota Medicaid, and must meet the criteria as defined in ARSD 67:54:09:12:

Eligibility Determination Process Overview



The following documentation is required to be submitted with the Level of Care:

- A completed Inventory for Client and Agency Planning (ICAP) assessment that indicates a minimum of three substantial functional limitations;
- Psychological examination to determine developmental disability or intellectual disability; and
- HCBS Waiver Rights Form (DHS-DD-717) to inform the applicant that services are available from the Home and Community Based Services Waiver.
    - This form also assures each applicant is provided with a list of HCBS providers, informed of the appeal process for denial of services if the applicant is determined not eligible, and provided with contact information to request a fair hearing; and
- A provisional plan of care that designates the specific waiver services that the individual will receive.

Annual Redeterminations

Eligibility re-evaluation is performed annually including a level of care review. From the level of care criteria described above, DHS uses a completed ICAP that resulted in a minimum of three functional limitations assessed by a Qualified Developmental Disability Professional (QDDP) or qualified DHS/DDD staff to re-evaluate whether the participant maintains minimum eligibility to receive Family Support 360 waiver services.

COVERED SERVICES AND LIMITS

The Family Support 360 waiver offers the following services are covered via waiver funds:

- Service coordination;
- Respite care;

- Specialized medical and adaptive equipment and supplies (SMAES);
- Environmental accessibility adaptive equipment;
- Vehicle modification;
- Personal care services;
- Personal care services extended state plan;
- Companion services;
- Supported employment;
- Nutritional supplements; and
- Specialized Therapies.

Family Support covers the following services using general funds only as there is not federal financial participation (FFP) available for the services:

- Child care;
- Counseling/support groups;
- Training/information;
- Housing assistance;
- Medical and dental services;
- Recreation, leisure, and social opportunities;
- Crisis situation vehicle modifications and repairs;
- Transportation; and
- Other Expenses.

Child Care

In order for participants to qualify for child care, service coordinators must first refer the family to the DSS Child Care Assistance Program and the participant must receive a denial for that program. The Child Care Assistance Program can be contacted via telephone at 605-773-4766.

Service coordinators must provide evidence of denial to the DDD prior to accessing Family Support coverage. Family Support will only fund the amount above the market rate for childcare costs for a child thirteen and under without a disability. Child care funding covers extra child care costs incurred due to the child's disability. Funding is also limited based on the program budget as well as by the amounts as agreed upon by the family, the Family Support Coordinator, and the DDD. DSS Child Care Assistance Program rules are available at https://dss.sd.gov/childcare/childcareassistance/.

Non-covered Services

Funding is not available and cannot be used to cover "typical" childcare costs that are generally incurred by a family.

Counseling/Support Groups

Counseling and support groups are covered and assist the participant/family with the costs of counseling on a sliding fee scale when such costs are not covered by Medicaid or other resources. Medicaid, community behavioral health resources (Community Mental Health Centers), and other

community services must first be exhausted, and evidence must be provided to DDD. Fees related to support groups may also be billed under this category.

Non-covered Services
Fees for counseling and support groups that are covered by Medicaid, private insurance, or other resources.

Training/Information
Training and information services may be covered. Service coordinators must refer the participant/family to the Council on Developmental Disabilities prior to accessing Family Support funding for conference registration fees.

Training/Information funding includes but is not limited to:

- Costs associated with conference registration for the participant and one support person;
- Costs associated with conference registration for the participant's family member to receive training and information on the participant's disability that qualifies them for Family Support;
- Cost of the room(s) and meals at the conference;
- Training materials, courses, and publications related to the participant's disability; and
- Materials that aid in communication (e.g., sign language training).

Non-covered Services

- Funding cannot be used to cover educational items related to a participant's IEP goals;
- Training and information provided by the service coordinator must be billed under the "Service Coordination" category; and
- Transportation costs related to traveling to conferences.

Housing Assistance
Housing assistance may be covered. Housing assistance is for a participant/family in a crisis situation. In order to be covered the participant must be experiencing one of the following crisis situations:

- At imminent risk of being homeless or institutionalized;
- Currently residing in an abusive, neglectful, exploitive or life-threatening situation; or
- The participant's health, welfare, or safety is in jeopardy due to the family/participant's inability to pay for the bill or item they are requesting assistance with.

Family Support Coordinators must explore all possible resources for funding outside of Family Support 360 prior to requesting funding. This includes utilizing family support funding to cost share with the family/participant. All requests will be reviewed closely to ensure that all community resources have been exhausted and that funding is not intended to be a long-term solution.

Housing Assistance funding includes, but is not limited to, the following if a participant meets the is in a crisis situation as described above:

- Rent;
- Security deposit on a rental;

- Utility deposit to enable a move;
- Utility payments in rare circumstances when the utility would otherwise be shut off;
- Purchase/repair of a home appliance;
- Repair of damage to the participant or family's owned home only if the participant is at a health and safety risk or is unable to access the home; and
- Necessary safety items in the home identified using the safety checklist (e.g., fire extinguishers, carbon monoxide detectors, smoke detectors, first aid kits for the home) if those items are not available from other resources.

Non-covered Services

- Damage done to the home that does not pose an immediate health or safety risk;
- Debts (such as back owned payments); and
- Long-term financial assistance related to any of the above allowable funding.

Medical and Dental Services

Assists the participant with emergency medical and dental work and co-payments for prescription medication not covered by another source. Financial assistance may also be provided for over-the-counter medication needed for a specific medical condition prescribed by a medical provider. Service Coordinators must access all other resources to pay for medication and dental expenses through Drug Company Programs, and Delta Dental (605-224-7345), etc.

Medical and dental coverage includes, but is not limited to:

- Emergency medical and dental work that is not covered by Medicaid and is determined to be medically necessary;
- Co-payments for a prescription medication not covered by another source.

Non-covered Services

- Coverage does not include over-the-counter medications or supplies for everyday use (e.g., aspirin, Tylenol, cough syrup, cotton balls, and Q-tips);
- Medication that is recommended, not prescribed, by a licensed provider; and
- Routine dental work.

Recreation, Leisure, and Social Opportunities

Funding for recreation, leisure, and social opportunities may be covered. The ISP must demonstrate that recreational opportunities promote inclusion, social relationships with others in the community, and provides a sense of purpose, and contributes to the shaping of who the individual is and how the individual fits into the community. Funding must be used to increase the participant's opportunity to access their community and interact with other members of the community. Funding is limited to $1,000 per plan year from June 1 to May 31.

Funding may also be provided for a sibling or friend to accompany the participant if no other funding is available, and the outcomes will be improved for the participant based on the attendance of a sibling or friend.

Recreation, leisure, and social opportunity funding includes but is not limited to:

- Summer camp fees;
- Health club/ YMCA class fees or memberships;
- Inclusive activity league fees;
- Inclusive community activities and events; and
- Adaptive recreational equipment.

Non-covered Services:

- Individual 1 on 1 lessons; and
- Purchasing recreational items such as kayaks, video games, trampolines, exercise equipment, etc.

Transportation

Service Coordinators can reimburse participants/families for mileage to attend a medical appointment or conference out of their hometown. Coordinators will follow the mileage, hotel, and meal reimbursement rates as prescribed by their CSP.

Transportation to medical appointments must be via Medicaid coverage, which includes Community Transportation, Secure Transportation, and Nonemergency Medical Travel (NEMT). Family Support funding can only be used to reimburse mileage for travel to medical appointments that are denied by Medicaid. Mileage reimbursements provided through the Transportation category encompass all costs of ongoing maintenance or repair of vehicles including tire replacement, oil changes, new brakes, etc.

The public transportation services to promote independence and community integration can be used to go to recreational activities or community events. This is typically purchased in the form of a public bus pass so there is limited capabilities for monitoring on how that is used by the participant. Reimbursement for gas or mileage cannot be used to travel to recreational activities or community events – Specifically, reimbursement of gas or mileage is not allowable.

Transportation coverage includes but is not limited to:

- Travel from an eligible recipient's city of residence to a medical provider located in another city, when not covered by Medicaid/NEMT. Mileage is limited to the actual miles between the two cities and does not include miles driven within the city;
- Travel reimbursement not covered by Medicaid/NEMT that is medically necessary as defined in ARSD 67:16:01:06.02 and is not furnished primarily for the convenience of the participant and/or their family;
- Public transportation services to medical appointments not covered by Medicaid or to a conference within their hometown;
- Public transportation services to promote independence and community integration.

Non-covered Services

- Paying in advance for mileage to medical appointments and conferences;

- Travel to recreational activities or community events;
- Mileage reimbursement to attend medical appointments covered by Medicaid/NEMT;
- Reimbursement in excess of what is already covered by Medicaid/NEMT reimbursement;
- Transportation to school; and
- Travel to non-medically necessary examinations or treatment.

Service Coordination
Services that assist participants who are receiving waiver services in gaining access to needed waiver and/or other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Service coordinators shall be responsible for monitoring the provisions of services included in the participant's plan at least quarterly.

Service coordinators must initiate and oversee the process of assessment and reassessment of the participant's level of care and the review of plans of care. Service Coordination includes assisting the participant/family with accessing resources, developing services and resources, purchasing services, arranging for natural supports and assessments, and monitoring activities.

Service coordinators can assist people with developmental disabilities and their families throughout the self-direction process by providing training and assistance to recruit, interview, hire, and train prospective providers. Service Coordinators can provide resources on the hiring process, including examples on how to write a want ad, examples of appropriate/non-appropriate interview questions, etc.

<u>Non-covered Services</u>

- Travel;
- Providing a direct support to the participant;
- Time spent with the participant or guardian for social reasons or discussing family complaints or issues instead of referring the family to appropriate resources;
- Non-participant specific general filings, meetings, conference calls, emails, correspondence, or training;
- Processing requests for payment, purchase orders, vouchers, or database entry;
- Any other services that do not comply with the most up-to-date version of this policy manual; and
- Time spent compiling information for compliance reviews.

Respite Care
Respite care may be covered. Respite care is a short-term service provided to participants who are unable to care for themselves, furnished on a frequency as determined in the plan of care because of the absence or need for relief of those persons who normally provide care. Respite care may not be an ongoing daily service, but is meant to provide intermittent, short-term, and short interval breaks for families. Respite Care may be provided in the following locations:

- Participant's home or place of residence including a foster home;
- Medicaid enrolled hospital;

- Group home; or
- A home approved in the plan of care which may be a private residence or licensed day care.

Respite care funding includes, but is not limited to:

- Providing the level of supervision and care that is necessary to ensure the participant's health and safety, this can include services which are related to personal care; and
- Services which are provided to assist waiver participants who are unable to be left alone due to health and safety concerns.

The Department of Human Services (DHS) Respite Care Program cannot be utilized when the participant is on the Family Support waiver.

Respite Care cannot be used:

- As daycare or childcare;
- As an ongoing, long-term part of daily services. This service is used as needed.
- During scheduled school hours if the participant is enrolled in school. This includes when the school is unexpectedly closed (example: snow day)
- When the parent/caregiver is working.

Specialized Medical and Adaptive Equipment and Supplies (SMAES)

SMAES may be covered. SMAES includes devices, controls, or appliances specified in the plan of care which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. All items shall meet applicable standards of manufacture, design, and installation. For an item to be funded under SMAES, it must meet all the following requirements:

- Items must be functionally necessary and relate specifically to the participant's medical need or disability that qualifies the individual for the Family Support waiver and be documented in the participant's service plan. SMAES must be based on a reasonable expectation that the item will likely improve the participant's functional abilities or the ability of a caregiver or service provider to maintain the participant in a community setting and delay or prevent institutional placement.
- SMAES are to be used for common activities of daily living, the promotion of increased independence with activities of daily living, and assurance of health and safety within the community.
- Items must provide a direct or remedial benefit to the participant and not otherwise be covered through the Medicaid State Plan.

Specialized Medical Adaptive Equipment and Supplies includes, but is not limited to:

- Modified bicycles or tricycles;
- Wheelchair parts and repairs;
- Adaptive clothing and specialized shoes;

- Communication devices/books recommended by the therapist, school, or doctor;
- Bathing lifts/chairs;
- Adaptive beds;
- Adaptive eating and cooking utensils;
- Medication reminders;
- Sensory equipment (sensory chew toys, small indoor trampolines, weighted blankets, platform swings, noise cancelling headphones, and sensory chairs);
- Electronic tablet as part of a system of environmental controls and as an augmentative communication device;
- Thickening agents;
- Specialized Car Seat (For specialized car seats first contact the Department of Social Services, Child Care Services, Child Safety Seat Distribution Program).

Non-covered Services

Items not covered include, but are not limited to:

- Therapies and therapeutic related items:
- Items used for leisure, recreation, education, and vocational purposes only and not determined to be necessary for the member to remain in their home or community;
- Non-adaptive items of clothing;
- Basic household furniture (e.g., beds for non-medical purposes);
- Non-medical supplies (e.g., cleaning products, routine personal care items);
- Educational items;
- Small home appliances;
- Televisions, stereos, radios, DVDs, and MP3 players;
- Toys (fidget toys, spinners, any other toys);
- Eyeglasses, frames, and lenses;
- Recreational or exercise equipment;
- Incontinence supplies;
- Items which are not of direct medical or remedial benefit to the participant; and
- Items covered under the Medicaid State Plan.

Therapist recommendations for SMAES is not required. SMAES equipment paid for by Family Support must have a denial from Medicaid and/or private insurance available prior to waiver funding being requested. The inclusion of a letter of recommendation with the request of an item is not a guarantee that the item will be approved. All items included in a letter of recommendation must meet the requirements list above.

Repair and/or replacement of equipment may be denied if it is determined there was misuse of the equipment.

Environmental Accessibility Adaptive Equipment

Environmental accessibility adaptive equipment may be covered. This equipment is a physical adaptation to the home, owned by the participant or the participant's family, required by the participant's

plan of care, which is necessary to ensure the health, welfare, and safety of the participant, or which enable the participant to function with greater independence in the home and without which, the participant would require institutionalization. Service Coordinators must access all other resources, (e.g., Independent Living Centers and/or local service groups as alternate resources) prior to accessing Family Support funding. All services must be provided in accordance with applicable State or local building codes. Service coordinators must receive two quotes for any modifications.

Environmental accessibility adaptive equipment includes, but is not limited to:

- Ramps (portable and permanent);
- Grab-bars;
- Widening of doorways;
- Bathroom modifications;
- Power door openers and door locks;
- Wheelchair lifts;
- Door sensors and cameras used to support an individual's independence in the home (Camera use is restricted to common areas of the home.);
- Ceiling track system personnel lifts (Portable patient lift options must be explored before installing a ceiling track system personal lift. Ceiling track systems should only be used if it significantly increases independence or safety and reduces the need for an attendant.); and
- Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant.
- Outdoor fences may be covered for individuals with documented unsafe wandering or running behaviors. Documentation from a qualified professional, such as a therapist or physician, must be provided during the request to demonstrate that the participant has unsafe wandering or running behaviors and the fence is necessary to ensure the health, welfare, and safety of the participant. Fencing coverage is limited to individuals age 4 or older. The waiver will pay up to $2,500 toward the cost of a fence.

Exceptions to service limits may be made on a case-by-case basis.

<u>Non-covered Services</u>

- Adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, home renovation, etc.; and
- Adaptations which add to the total square footage of the home.

Vehicle Modification

Vehicle modifications may be covered. Vehicle Modifications consist of adaptations or alterations to an automobile or van to accommodate the special needs of the participant. The vehicle must be the waiver participant's primary means of transportation. Vehicle adaptations are specified by the plan of care as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare, and safety of the participant. Service coordinators must receive two quotes for any modifications.

Vehicle modification funding includes, but is not limited to:

- Conversions including rear, side access, and pickup;
- Mobility seating; and
- Wheelchair vehicle lifts.

Non-covered Services

- Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant;
- Purchase or lease of a vehicle; and
- Regularly scheduled upkeep and maintenance of a vehicle not including upkeep and maintenance of modifications.

Crisis Situation Vehicle Modifications and Repair

Financial assistance may be provided to assist the participant/family in a crisis situation for emergency vehicle repairs to the primary vehicle used for transportation of the participant to enable the participant and/or family to travel to necessary medical appointments. A crisis situation means the participant is at imminent risk of not receiving necessary medical care (this excludes preventative well-child visits and other care that is non-emergent or non-urgent) as a result of maintenance issues involving the primary vehicle used for transportation of the participant and their health is in jeopardy due to the family's inability to pay for the repairs.

Request for funding in this category must include documentation of the type and frequency of medical appointments or care that the participant is unable to attend without the repair. Family Support Coordinators must explore all possible resources for funding outside of Family Support prior to requesting funding, which could include the possibility of utilizing family support funding to cost share with the family. Transportation to medical appointments via Medicaid covered transportation must be utilized if available. All requests will be reviewed closely to prevent a misuse of funding.

Non-covered Services

- Ongoing maintenance and repair of vehicles such as tire replacement, oil changes, heat, and a/c systems maintenance, etc.; and
- Vehicle auto body repairs including any damage due to a collision or weather damage (hail damage, paint chipping).

Mileage reimbursements provided through the Transportation category encompass any and all costs of ongoing maintenance or repair of vehicles including tire replacement, oil changes, etc.

Personal Care Services (Self-Directed)

Personal care services may be covered. Allowable services under this category are to assist the participant in accessing the community or assist the participant in the home with bathing, dressing, personal hygiene, activities of daily living and eating. Personal care providers must meet State

standards for this service. The provider may be a member of the participant's family if the family member is not one of the individuals listed in the non-covered services section.

Personal care coverage includes, but is not limited to:

- Assisting the participant in the home with bathing, dressing, personal hygiene, activities of daily living and eating;
- Assistance with the preparation of meals, not including the cost of the meals themselves; and
- When specified in the plan of care, this service may also include housekeeping chores such as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the participant, rather than the participant's family.

Non-covered Services

Payment will not be made for personal care services furnished to a minor by the child's parent, the parent's spouse, the parent's significant other, the participant's spouse, or the participant's significant other.

Personal Care Services Extended State Plan

Personal care extended state plan services may be covered. This includes a range of assistance provided to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability, including assistance with eating, bathing, personal hygiene, and activities of daily living. This assistance may take the form of hands-on assistance (performing a task for a participant) or cueing/prompting the participant to perform a task. Personal care extended state plan is provided as indicated in the approved service plan. Personal care extended state plan services may be provided on a sporadic or continuing basis.

Personal Care Extended State Plan services provided through the Family Support waiver can enhance the amount, duration, or frequency of State Plan services. Personal care extended state plan services are billable as a waiver service after the 500-hour Medicaid State Plan annual limit is met.

Providers qualified to perform Personal Care Extended State Plan services are limited to Home Health Agencies, which is an organization which is primarily engaged in providing skilled nursing, medical social services, or home health aide services and meets Code of Federal Regulation requirements of a home health provider.

Companion Services

Companion services may be covered. Companion services are non-medical and include supervised integrated socialization, role modeling, and independent living skill development. Companion services may include hands-on assistance or cuing to prompt the participant to perform a task. Companion care must be provided in accordance with a goal in the service plan. The service coordinator must assist with the self-directed needs of the participant when recruiting, hiring, and training companion care staff.

Companion care services may include, but are not limited to, skill development including such tasks as assistance and/or supervision of meal preparation, laundry and shopping, navigation of public

transportation, assistance and/or supervision with acquisition, retention or improvement in self-help, socialization, and adaptive skills.

Service Restrictions

- The service cannot be provided to a minor by their parent, their parent's spouse, or their parent's significant other
- The service cannot be provided to a participant by their spouse or the their significant other
- The service cannot be used while the person is sleeping.
- The service cannot be used during scheduled school hours if school is open. However, the service can be used if school is on a scheduled break like Summer Break, Winter Break, Thanksgiving, etc.
- If the participant is under the age of 13, the service cannot be used during scheduled school hours if school is unexpectedly closed for all students (example: snow day). However, if the participant is 13 or older and they cannot be home unsupervised, the service can be provided during this time. The service must still comply with the guidelines above.

Supported Employment

Supported employment may be a covered service. Supported employment services consists of helping a participant obtain paid employment if the participants is unlikely to obtain competitive employment at or above the minimum wage is because of their disabilities need intensive ongoing support to perform in a work setting. Service Coordinators must refer participants to the Division of Rehabilitation Services (students ages 16 and older for Project Skills) prior to accessing supported employment services through Family Support.

Supported employment is conducted in a variety of settings including work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants receiving waiver services including supervision and training. When supported employment services are provided at a worksite in which persons without disabilities are employed, payment will only be made for the adaptations, supervision and training required by participants 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. Supported employment services are directed towards assisting participants to obtain and retain paid employment in community settings. The coordinator must assist with the self-directed needs of the participant when recruiting, hiring, and training supported employment staff.

Documentation will be maintained in the file of each participant receiving this service that the service is not otherwise available under a program funded by either the Rehabilitation Act of 1973, or the IDEA. For example, a provider may include documentation that states "The employment supports are not part of the participant's IEP or the participant has been determined to not meet eligibility or has had a successful closure from Vocational Rehabilitation."

Supported employment services include, but are not limited to:

- Person centered employment planning;
- Employment assessment;

- Assistive technology assessment;
- Travel training;
- Community based work experience;
- Financial literacy education;
- Marketing/Job development;
- Soft skills assistance;
- Job coaching;
- Engagement of natural supports during initial period of employment;
- Employer check-in; and
- Long-term support to help participant maintain integrated employment.

Non-covered Services

- Services furnished to a minor by the child's parent, the parent's spouse, the parent's significant other, the participant's spouse, or the participant's significant other;
- Transportation between the participant's place of residence and the site of the habilitation services or between habilitation sites. The cost of transportation is not included in the rate paid to providers of the supported employment;
- Time the participant spends producing goods or providing services; and
- Compensation for participants.

Nutritional Supplements

Nutritional supplements may be covered. Nutritional supplements are products that are used to complement a participant's dietary needs (e.g., total parenteral products, enteral products, and meal replacement products). Medicaid State Plan coverage includes PKU formula, Pediasure, and similar products. Medicaid State Plan coverage must be accessed prior to accessing coverage through Family Support. A prescription needs to be maintained in the file and updated annually. The purchase of groceries is not an allowable expense as a nutritional supplement.

Nutritional supplements coverage includes, but is not limited to:

- Boost;
- Ensure; and
- Pediasure.

Non-covered Services

- Medications;
- Dietary supplements (e.g., vitamins); and
- Groceries.

Specialized Therapies- Annual Waiver limit $1,500

Music therapy is used to help recipients improve their cognitive functioning, motor skills, emotional and affective development, behavior and social skills and their quality of life. Music therapy may be provided individually or with others in groups.

Art therapy is used to:

- Increase awareness of self and others;
- Cope with symptoms, stress, and traumatic experiences; and
- Enhance cognitive abilities.

Hippotherapy/therapeutic horseback riding is used to promote the use of the movement of the horse as a treatment strategy in physical, occupational, and speech-language therapy sessions for people living with disabilities. The movement of the horse provides physical and sensory input, which is variable, rhythmic, and repetitive. Equine movement coerces the recipient to use muscles and body systems in response to movement of the horse.

Specialized Therapy services must be delivered by state/and or national board-certified therapists.

Specialized therapy services may include but are not limited to:

- Music therapy
- Art therapy
- Hippotherapy
- Therapeutic horseback riding

Non-covered services:
Payment will not be made for therapy services furnished by therapists who do not meet the qualifications standards.

Other Expenses
The use of the "Other Expenses" category is only allowable if the covered item or service is not billable under a more specific service described above. In addition, there must be an urgent need for a participant that is related to the disability that qualifies the individual for Family Support. The other category must not be used to bill for non-covered services.

The following items are covered under the other expenses category:

- Advertisement cost for respite care, personal care, or companion care providers;
- Birth certificates needed for Family Support documentation;
- Interpreter/translation services;
- GPS tracking system or similar devices when there is a need due to safety issues; and
- Cost of attorney fees for establishing a guardianship up to $750.

NON-COVERED SERVICES

General Non-Covered Services
Home and community based waiver services coverage is limited to services not available under the Medicaid State Plan. Services do not include room and board.

Items and services not covered include, but are not limited to:

- Vehicle or trailer purchases;
- Incontinence Supplies;
- Groceries;

- Furniture (unless adaptive in nature);
- Weddings, divorces, or funerals;
- Swimming pools;
- Cable, satellite, or streaming television services (includes installation and monthly service charges);
- Internet or cell phone services (includes installation and monthly service charges);
- Gift cards;
- Cash advances; and
- State and/or federal taxes.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

The provider agrees to maintain or supervise the maintenance of records necessary for the proper and efficient operation of the program, including records and documents regarding applications, determination of eligibility (when applicable), the provision of services, administrative costs, statistical, fiscal, other records, and information necessary for reporting and accountability required by the State. The Provider shall retain such records for six years following termination of the agreement. If such records are under pending audit, the provider agrees to hold such records for a longer period upon notification from the State. The State, through any authorized representative, will have access to and the right to examine and copy all records, books, papers, or documents related to services rendered.

Family Support 360 Documentation

Any entry in the participant's record must be dated and signed and must include information, which is accurate, complete, timely, and relevant to the participant's needs for services or supports.

A copy of the participant's paper or electronic record must be in a format accessible to the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any. If abbreviations and symbols, acronyms, or jargon are used, a key shall be provided.

The participant's paper or electronic record must be held in a location accessible to the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any, and the division and CSP staff and must include:

- The participant's full name;
- The participant's social security number;
- The date of HCBS eligibility;
- The current address and phone number of the participant;
- A summary of health insurance, financial support, and other entitlements;

- Any identification of family, guardian, conservator, and other interested persons, including current addresses and telephone numbers;
- The status of legal capacity;
- Documentation of all providers of services or supports including qualified providers, OHCDS subcontractors, and employees employed through the agency with choice model, during the past two years;
- Any employment history, including a list of employers, dates of employment, and any position held;
- The current assessment reports;
- Any critical incident reports;
- The identity of the responsible party for the management of participant funds;
- The quarterly progress notes;
- The participant's current ISP; and
- Any support plan for services.

SERVICE COORDINATION CLAIM PROCEDURES

A billable unit consists of a minimum of 8 minutes. Billable minutes entered into FOCoS will be combined throughout the day for each participant. Service coordinators must combine all billable minutes for a participant for the day to determine the total billable units and apply half up rounding for the total minutes per day. For example: 1 unit= 8-22 minutes, 2 units= 23-37 minutes, 3 units= 38-52 minutes, and 4 units= 53-67 minutes.

The following categories listed below include examples of the types of activities that would fall under service coordination. These examples are not intended to be an all-inclusive listing.

Assessment and Reassessment

- Completion of personal outcome measures, ICAP, or any other assessment actually completed by the service coordinator.
- Review of assessments completed outside of preparation of annual ISP meeting. This could include review of assessments throughout the year that do not result in changes to a person's service plan.

Critical Incident Reporting (CIR) and Follow Up

- Reporting of any incident as defined in ARSD 46:11:09:05.
- Meetings, phone calls and e-mails concerning a CIR or follow up to a CIR.

Collateral Contacts

- Contact with any person or other source of information regarding assisting the participant to access resources, develop services, purchase services, arrange for natural supports, and monitor activities related to the goals outlined in the service plan.

Contact with Guardian, Family

- Phone calls, e-mails or any other type of contact made with a family member or guardian in assisting the participant to access resources, develop services, purchase services, arrange for natural supports, and monitor activities related to the goals outlined in the service plan.

Contact with Participant

- Phone calls, e-mails or any other type of contact made with the participant in assisting the participant to access resources, develop services, purchase services, arrange for natural supports, and monitor activities related to the goals outlined in the service plan.

Coordination of Natural Supports

- Phone calls, e-mails or any other type of contact made with family members, friends, neighbors, co-workers, churches, community members, employers, etc. to assist the person to participate in activities without paid support and/or to enhance the role of the natural support in advocacy related individually to the needs of the participant as described in their service plan. One contact to a community member or organization cannot be billed for multiple recipients.

Crisis Intervention

- Activities revolved around connecting participants with natural and paid supports in response to a crisis situation in which the participant is at imminent risk of being homeless or institutionalized, residing in an abusive, neglectful, exploitive, or life-threatening situation, or whose health, welfare, or safety is in jeopardy.

Service Plan Development

- Annual completion and review of assessments of individual needs to develop, revise and update the service plan.
- Establishment of needs and goals for an individual which could include team meetings and phone calls associated with developing the service plan.
- Facilitation and writing of the service plan.
- Meetings, phone calls or e-mails related to the development or revision of the service plan.

Quarterly Monitoring

- Any activity that involves monitoring of the participant's services and budget as described in the service plan.

Referral and Related Activities to Other Resources

- Assistance in informing participants of resources like Statewide Family Support, Medicaid State Plan services, educational, employment, social, medical, individual budget, protection and advocacy and other services
- Assistance in helping participants gain access to those services by providing contact information, application information, or other additional resources
- Assistance in transferring a participant from one program to another

Team Meeting

- Team meetings requested by the participant outside of the service plan development annual meeting.
- Attending IEP meetings at the request of the participant/family.

Training Provided to Participant

- Participant specific training provided in person, that provides in-depth information on ANE, grievance and rights and is more than just sharing a brochure or document.

Non-covered Services

Non-covered services include:

- Travel;
- Providing a direct support to the participant;
- Time spent with the participant or guardian for social reasons and over involvement in family complaints and strife instead of referring the family to appropriate counseling resources;
- Non-participant specific general filing, meetings, conference calls, emails, correspondence or training;
- Processing requests for payment, purchase orders, vouchers or database entry;
- Any other services that do no comply with the most up-to-date financial assistance guidelines;
- Time spent compiling information for compliance reviews.

Documentation Requirements

A claim for billable service coordination with an internal comment is required to be entered into the FOCoS system within 14 days and batched as a claim within 30 days following the end of the month in which services were provided. The internal comment must be able to support the time being billed and be descriptive about the activities that were performed to justify the units being billed. The internal comment must also include the person who the service is provided to and if any follow-up is needed. Service coordinators should submit one claim for service coordination per participant per day. Up to two units may be billed for emails/texts per day. Service coordinators must be able to reconcile units billed with actual texts/emails to support the amount of time billed.

<u>Examples of an acceptable internal comment:</u>

- Phone contact with John. Discussed with John how his health has been. He indicated he is not feeling 100 percent. Asked John if he knew how to get in contact with the doctor to set up an appointment. Shared resources with John on urgent care facilities in his area that he could go to if he felt like he needed more urgent assistance. After reviewing John's file, I advised him I needed to set up a meeting with him to go over the details of his service plan and needed to go through some questions with him. Went through the questions I had and spent some time discussing other services that John has been receiving since we last talked. Set up a time to meet for the following week.

- John said he's concerned about keeping his sidewalks free from ice and about getting stranded on his way to Sioux Falls for an appointment. Research ice prevention and discussed what John is capable of and what he might need help with, found neighbors and church members willing to

help John. Taught John how to look up road and weather information; discussed having a winter kit for his car when he travels, including proper outdoor attire. John didn't have gloves. Contacted his support professional to take him shopping for gloves.

Examples of an unacceptable internal comment:

- Phone call with John;
    - Reason deficient: Needs to include what the phone call was about and provide detail of the conversation.
- Research information on winter weather preparedness. Locate and compile information and mail out to participant;
    - Reason deficient: Generic and not specific to the participant. There needs to be information that is individually specific in the internal comments to meet the documentation requirements.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

Provider agrees to submit an initial bill for services within 30 days following the end of the month in which services were provided. If the provider cannot submit a bill within the 30-day timeframe, a written request for an extension of time must be provided to the State. If a bill has not been received by the State, the State reserves the right to refuse payment.

An exception to this is when a provider is waiting for program/funding eligibility determination and billing cannot be made within 30 days. Valid adjustments and/or voiding of claims can continue to occur past the 30-day timeframe.

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability

Medicaid participants may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement

Services are reimbursable when provided according to the participant's approved service plan. Current service unit rates are available on the Medicaid fee schedule webpage.

Claim Instructions

Claims are submitted electronically through FOCoS. For further information please contact FOCoS using one of these methods:

- FOCoS Provider Support: 1-888-448-4776
- FOCoS Fax Line: 1-877-578-5561
- FOCoS Email: support@focosinnovations.com

DEFINITIONS

1. "Advocate," any individual designated by a participant to support that participant by speaking or acting on the participant's behalf;

2. "Certification," the department decision following procedures in chapter 46:11:02 which entitles an organization to receive government funds and provide services to participants;

3. "Community support provider (CSP)," a nonprofit provider of services as defined in SDCL subdivision 27B-1-17(4);

4. "Conservator," as defined in SDCL subdivision 29A-5-102(2);

5. "Department," the Department of Human Services;

6. "Developmental disability," a disability as defined by SDCL 27B-1-18;

7. "Division," the Division of Developmental Disabilities, a division of the Department of Human Services;

8. "Family," a person or a group of people who are related to the participant by blood, marriage, or adoption, or as defined by the participant as a family based upon bonds of affection. For the purposes of this subdivision, the phrase, bonds of affection, means enduring ties that do not depend on the existence of an economic relationship and the relationship is expected to endure over time;

9. "Participant," a person receiving services or supports under the provisions of the CHOICES waiver;

10. "Community services provider or SP," a for-profit or a not-for-profit provider of services, as defined in SDCL subdivision 27B-1-17(4);

11. "Provider," a CSP or a SP.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- Code of Federal Regulations