LOUISIANA DEPARTMENT OF HEALTH

COMMUNITY CHOICES WAIVER

Chapter Seven of the Medicaid Services Manual

Issued July 1, 2013

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

COMMUNITY CHOICES WAIVER

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OVERVIEW

The Community Choices Waiver (CCW) is a Medicaid Home and Community-Based Services (HCBS) Waiver providing an array of alternative services to individuals that assist them to live in their own home or community instead of in a nursing facility or institution.

This provider manual chapter specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is a combination of federal and state laws and Louisiana Department of Health (LDH) policy which provides direction for provision of these services to eligible individuals in the State of Louisiana.

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services and proper fund disbursement. Should a conflict exist between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This manual chapter is intended to provide CCW providers and support coordination agencies (SCAs) with the information necessary to fulfill their vendor contract with the State of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for an agency or provider to remain in compliance with federal and state laws and department rules.

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website (below) for general information concerning topics relative to Medicaid provider enrollment and administration at http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

The LDH Bureau of Health Services Financing (BHSF), Office of Aging and Adult Services (OAAS) and/or Health Standards Section (HSS) are responsible for assuring oversight of the waiver services, licensure compliance, program monitoring, and overall compliance with the rules and regulations.

Waiver services to be provided are specified in the plan of care (POC) which is written by the support coordinator, based on input from the planning team. The planning team is comprised of the beneficiary, the support coordinator, and in accordance with the beneficiary's preferences, members of the family/natural support system, appropriate professionals and others whom the beneficiary chooses. The POC contains all services and activities involving the beneficiary, non-waiver as well as waiver services. Beneficiaries are to receive those waiver services included in the POC (as applicable). Notification of approved services is forwarded to the provider by the support coordinator, and the data contactor issues prior authorization (PA) to the providers based

on the approved POC.

The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the approved waiver application/document with the Centers for Medicare and Medicaid Services (CMS).

COVERED SERVICES

This section provides information about the services that are covered in the Community Choices Waiver (CCW) program. For the purpose of this policy, when reference is made to "individual" or "beneficiary", this includes that person's responsible representative, legal representative(s) and/or family member(s), as applicable, who are assisting that person in obtaining services.

NOTE: Beneficiaries who are approved for CCW cannot receive Long-Term - Personal Care Services (LT-PCS).

Support Coordination

Support coordination, also referred to as case management, is a mandatory service in the CCW program. It is designed to assist beneficiaries in prioritizing and defining their personal outcomes and gaining access to necessary waiver and other State Plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordination agencies (SCAs) must perform the following core elements of support coordination:

1. Intake;
2. Assessment and re-assessment;
3. Plan of care (POC) development and revision;
4. Follow-up/monitoring;
5. Critical incident management; and
6. Transition/discharge and closure.

SCAs are also required to perform the following duties:

1. Evaluation/re-evaluation of level of care (LOC) and need for waiver services;
2. Linkage to direct services and other resources;
3. Assessing, addressing, and documenting the delivery of services, including remediation of difficulties encountered by beneficiaries in receiving direct services;
4. Coordination of multiple services among multiple providers;

5. Ongoing assessment and mitigation of health, behavioral and personal safety risks; and

6. Responding to beneficiary crises.

The support coordinator is responsible for coordination of the beneficiary's CCW services in a way that does not duplicate services when the beneficiary is also receiving other services, such as home health, or hospice services.

Support coordination services are provided by SCAs. SCAs shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen the agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The Office of Aging and Adult Services (OAAS) must be immediately notified of the circumstances surrounding a refusal to provide/continue to provide services. This requirement can only be waived by OAAS.

SCAs must establish and maintain effective communication and good working relationships with each of the beneficiary's service providers.

For additional details on Support Coordination/SCAs responsibilities, procedures, and timelines, refer to Appendix B for the link to OAAS Waiver Procedures Manual: For Regional Offices (ROs) and SCAs.

Beneficiaries must be given information and assistance in directing and managing their services. When beneficiaries choose to self-direct their personal assistance services (PAS), support coordinators must inform beneficiaries about their responsibilities as a self-direction employer and compliance with all applicable state and federal laws, rules, policies, and procedures.

Support coordinators shall be available to beneficiaries and/or self-direction employers for on-going support and assistance in these decision-making areas regarding self-direction employer responsibilities. (See Appendix B for information on accessing the *"OAAS Community Choices Waiver Self-Direction Employer Handbook"*).

Transition Intensive Support Coordination

Transition intensive support coordination (TISC) is a service that assists individuals who are currently residing in nursing facilities who want to transition into the community. This service assists individuals in gaining access to needed waiver and other Medicaid State Plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services.

TISC services are provided by SCAs. SCAs shall comply with all requirements described in the "Support Coordination" section listed above this section. SCAs shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the beneficiary's approved POC. (See Appendix F for a complete list of the CCW services available during the transition process).

Service Exclusions

SCAs are not allowed to bill for TISC until after the individual has been approved for the CCW.

The scope of TISC shall not overlap with the scope of support coordination; therefore, duplicate billing is not allowed.

Service Limitations

SCAs may be reimbursed up to six months (not to exceed 180 calendar days) from the POC approval date for the months that the beneficiary was residing in a nursing facility. Reimbursement is contingent upon the SCA performing activities necessary to arrange for the individual to live in the community. These activities must be documented by the support coordinator. SCAs will not receive reimbursement for any month during which no activity was performed and documented in the transition process.

Transition Services

Transition services assist an individual, who has been approved for a CCW opportunity, to leave a nursing facility and return to live in the community.

Transition services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for a CCW opportunity, and who are transitioning from a nursing facility to their own living arrangement in a private residence where the individual is directly responsible for their own living expenses. Transition services may also be used to purchase essential items needed for the individual even when the individual is residing with others. Allowable expenses are those necessary to enable the individual to establish a basic household, excluding expenses for room and board. These services must be identified and approved in the individual's POC in accordance with the Louisiana Department of Health (LDH) and OAAS policies and procedures.

Transition services include the following:

1. Security deposits that are required to obtain a lease on an apartment or house;

2. Specific set-up fees or deposits for the following:

a. Telephone;

b. Electricity;

c. Gas;

d. Water; and

e. Other such necessary housing start-up fees or deposits, including outstanding balances for past due charges and/or fees.

3. Activities to assess need, arrange for and procure needed resources (e.g. fees associated with obtaining photo identification (ID) cards or vital records, housing application fees, etc.);

4. Essential furnishings to establish basic living arrangements, including the following:

a. Living room – sofa/love seat, chair, coffee table, end table and recliner;

b. Dining room – dining table and chairs;

c. Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers, nightstand, comforter, sheets, pillows, lamp, and telephone;

d. Kitchen – refrigerator, stove, cook top, dishwasher, convection oven, dishes/plates, glassware, cutlery/flatware, microwave, coffee maker, toaster, crock pot, indoor grill, pots/pans, drain board, storage containers, blender, can opener, food processor, mixer, dishcloths, towels, and potholders;

e. Bathroom – towels, hamper, shower curtain, and bath mat; and

f. Miscellaneous – window coverings, window blinds, curtain rod, washer, dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron, and ironing board.

5. Moving expenses – moving company and cleaners (prior to move, one-time expense); and

6. Health and welfare assurances, as follows:

a. Pest control/eradication;

b. Fire extinguisher;

c. Smoke detector; and

d. First aid supplies/kit.

NOTE: Support coordinators must exhaust all other resources to obtain these items prior to utilizing the waiver.

Service Exclusions

Transition services do not include the following:

1. Monthly rental payments;
2. Mortgage payments;
3. Food;
4. Monthly utility charges; and
5. Household appliances and/or items intended solely for diversional/recreational purposes (e.g., television, stereo, computer, etc.).

The service exclusions listed above do not constitute room and board. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

Service Limitations

There is a $1,500 lifetime maximum limit per beneficiary. Services must be prior approved by the OAAS RO or its designee and require prior authorization (PA).

NOTE: This waiver service is NOT subject to deduction from the beneficiary's annual POC budget.

When the beneficiary transitions to a home/apartment that is inhabited with another person, services will only be available for items that are to be used exclusively by the beneficiary.

The purchaser for these items may be the beneficiary, the responsible representative, the direct service provider (DSP), the SCA, or any other source. However, the SCA is the **ONLY** source that can bill for these services.

Environmental Accessibility Adaptations

Environmental accessibility adaptations (EAAs) are those necessary physical adaptations made to the home to reasonably assure the health and welfare of the beneficiary, or enable the beneficiary to function with greater independence in the home. Without these necessary adaptations, the beneficiary would require institutionalization.

NOTE: Necessity is determined when all options (Durable Medical Equipment (DME), assistive technology, etc.) have been explored and exhausted, or found to be ineffective for justifiable reasons.

There must be an identified need for an EAA as indicated by the interRAI Home Care Assessment (iHC) or other supporting documentation.

All costs associated with the EAA service (e.g., initial home evaluation also referred to as the basic assessment, final inspection, costs of DME, costs of construction, etc.) are subject to the beneficiary's annual budget allotment.

If the beneficiary does not own the home, written permission from the landlord **MUST** be obtained prior to proceeding with EAAs which require structural modification(s).

All proposed EAAs documented in the home access evaluation (HAE) report must be reviewed by the OAAS RO before proceeding.

Upon completion of any structural modification(s), the EAA assessor or OAAS must ensure that all specifications have been satisfactorily met before payment shall be made to the provider that completed the work.

NOTE: If OAAS or the EAA assessor determines that the work of the EAA provider is substandard, the EAA provider who completed the work shall be responsible for the costs associated with bringing the work up to standard, including but not limited to materials, labor, and costs of any subsequent inspections. If the substandard work is the result of the EAA assessor's HAE report, the EAA assessor shall be responsible for the associated costs indicated above.

The adaptation(s) must be accepted, fully delivered, installed, and operational in the current POC year that it was approved, unless otherwise approved by OAAS or its designee.

EAAs include the following:

1. Ramps, such as:
    a. Portable; and
    b. Fixed.
2. Lifts, such as:
    a. Porch;
    b. Stair;
    c. Hydraulic;
    d. Manual; and
    e. Electronic.
3. Modifications of bathroom facilities, such as:
    a. Roll shower;
    b. Sink;
    c. Bathtub;
    d. Toilet; and
    e. Plumbing.
4. Additions to bathroom facilities, such as:
    a. Roll shower;
    b. Water faucet controls;
    c. Floor urinal;
    d. Bidet; and

e. Turnaround space.

5. Specialized accessibility/safety adaptations/additions, such as:

a. Door widening;

b. Electrical wiring;

c. Grab bars;

d. Handrails;

e. Automatic door opener/doorbell;

f. Voice activated, light activated, motion activated, and electronic devices;

g. Fire safety adaptations;

h. Medically necessary air filtering device*;

i. Medically necessary heating/cooling adaptations*; and

j. Other modifications to the home necessary for medical or personal safety.

***A medical doctor's statement concerning medical necessity for air filtering devices and heating/cooling adaptations is required. The support coordinator must obtain such documentation prior to requesting approval from the OAAS RO, or its designee, and must maintain the documentation in the beneficiary's records.**

EAAs shall be authorized only if the beneficiary's health and welfare can be reasonably assured for the duration of the POC year within the beneficiary's remaining resource allocation.

Environmental Accessibility Adaptation Service Exclusions

This service is not intended to cover basic construction costs. For example, in a new home, a bathroom is already part of the building costs and waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

The following adaptations are not included in this service:

1. General house repairs;

2. Flooring (carpet, wood, vinyl, tile, stone, marble, etc.);

3. Interior/exterior walls not directly affected by an adaptation;

4. Lighting or light fixtures that are for non-medical use;

5. Furniture;

6. Vehicle adaptations;

7. Roofing, initial or repairs. This also includes covered ramps, walkways, parking areas, etc.;

8. Exterior fences or repairs made to any such structure;

9. Motion detector or alarm systems for security, fire, etc.;

10. Fire sprinklers, extinguishers, hoses, etc.;

11. Smoke, fire, and carbon monoxide detectors;

12. Interior/exterior non-portable oxygen sites;

13. Replacement of toilets, septic system, cabinets, sinks, counter tops, faucets, windows, electrical or telephone wiring or fixtures when not affected by an adaptation, not part of the installation process or not one of the pieces of medical equipment being installed;

14. Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.);

15. Any service covered by the Medicaid State Plan; or

16. Any equipment or supply covered by Medicaid DME program.

NOTE: Some lifts, filters, etc., may be covered as a DME item. The support coordinator must first explore the possibility of these items being covered through the DME program by assisting the beneficiary in making a PA request with a DME provider.

Service Limitations

Services must be reviewed by the OAAS RO or its designee and be prior authorized.

It is strictly prohibited for the EAA provider to charge the beneficiary an amount in excess of the prior approved amount for completion of the job.

Personal Assistance Services

PAS include assistance and/or supervision necessary for the beneficiary with functional impairments to remain safely in the community. PAS includes the following services and supports based on the approved POC:

1. Supervision or assistance in performing activities of daily living (ADL);

2. Supervision or assistance in performing instrumental activities of daily living (IADL);

3. Protective supervision solely to assure the health and welfare of the beneficiary;

4. Supervision or assistance with health-related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration;

5. Supervision or assistance while escorting/accompanying the beneficiary outside the home to perform tasks, including IADL, health maintenance or other needs as identified in the POC and to provide the same supervision or assistance as would be provided in the home; and

6. Extension of therapy services, defined as the following:

    a. Assistance in reinforcing instruction and aids in the rehabilitative process by an attendant who has been instructed by a licensed therapist on the proper way to assist the beneficiary in follow-up therapy sessions; and

    b. Performance of basic interventions by an attendant who has been instructed by a registered nurse (RN) on how to increase and optimize functional abilities in performing ADL, such as range of motion exercise.

Transportation is not a required component of PAS although providers may choose to furnish transportation for beneficiaries during the course of providing PAS. If transportation is furnished, the provider must accept all liability for its employee transporting a beneficiary. It is the responsibility of the provider to ensure that the employee has a current, valid driver's license and automobile liability insurance.

PAS workers can be any one of the following relations of the beneficiary, as long as they meet the

worker requirements:

1. Spouse*;
2. Curator;
3. Tutor;
4. Legal guardian; or
5. Person to whom the beneficiary has given representative and mandate authority (also known as power of attorney).

*For the spouse to be the worker, refer to Legally Responsible Individual (LRI)/Spouse and Extraordinary Care Criteria section later in this section.

PAS is provided in the beneficiary's home or can be provided in another location outside of the beneficiary's home if the provision of these services allows the beneficiary to participate in normal life activities pertaining to the ADL and IADL cited in the POC. In cases where a beneficiary goes to the emergency room (ER), the PAS direct service worker (DSW) may provide assistance up until the time the beneficiary is admitted to the hospital.

When beneficiaries plan to travel outside of Louisiana, there must be a written request (that includes a detailed explanation) submitted to OAAS or its designee at least 24 hours prior to the anticipated travel (when applicable).

The PAS allotment may be used flexibly in accordance with the beneficiary's preferences and personal schedule and with OAAS' documentation requirements when the following guidelines are met:

1. Approved allocation must be used in accordance with the beneficiary's preferences within a single, specific PA period;
2. Unused portions of the prior authorized allocation may not be saved or borrowed from one prior authorized period to another;
3. Total hours used may not exceed the prior authorized period amount;
4. Variations from the approved POC in accordance with the beneficiary's preference must be documented by the DSW on the designated CCW service log. (See Section 7.7 – *Record Keeping* of this manual chapter); and

5. Need for paid support/assistance with particular tasks/services, without assignment of specific time per task, must be documented in the approved POC.

Supervision or Assistance with Activities of Daily Living

Beneficiaries may receive supervision or assistance in performing the following ADL for their continued well-being and health:

1. Eating, including the following:

    a. Verbally reminding the beneficiary to eat;

    b. Cutting food into bite-size pieces;

    c. Assisting the beneficiary with feeding; and/or

    d. Assisting the beneficiary with adaptive feeding devices.

NOTE: Assistance does **NOT** include tube feeding unless the DSW has received the required training pursuant to La. R.S. 37:1031-1034.

2. Bathing, including the following:

    a. Verbally reminding the beneficiary to bathe;

    b. Preparing the beneficiary's bath;

    c. Assisting the beneficiary with dressing and undressing; or

    d. Assisting the beneficiary with prosthetic devices.

3. Dressing, including the following:

    a. Verbally reminding the beneficiary to dress;

    b. Assisting the beneficiary with dressing and undressing; or

    c. Assisting the beneficiary with prosthetic devices.

4. Grooming, including the following:

    a. Verbally reminding the beneficiary to groom;

    b. Assisting the beneficiary with shaving, applying make-up, body lotion or cream;

    c. Brushing or combing the beneficiary's hair;

    d. Brushing the beneficiary's teeth; or

    e. Other grooming activities.

5. Transferring, including the following:

    a. Assisting the beneficiary with moving body weight from one surface to another, such as moving from a bed to a chair; or

    b. Assisting the beneficiary with moving from a wheelchair to a standing position.

6. Ambulation, including the following:

    a. Assisting the beneficiary with walking (regardless of assistive device); or

    b. Assisting the beneficiary with wheelchair use.

7. Toileting, including the following:

    a. Verbally reminding the beneficiary to toilet;

    b. Assisting the beneficiary with bladder and/or bowel requirements, including bedpan routines and changing incontinence pads or adult briefs, if required; or

    c. Draining/emptying a catheter or ostomy bag.

NOTE: Assistance does **NOT** include removing or changing catheter and/or ostomy bags or tubing, inserting, removing, and sterilizing irrigation of catheters unless the DSW has received the required training pursuant to La. R.S. 37:1031-1034.

Assistance or support with ADL tasks does not include teaching family/friends/others how to care for the beneficiary.

Supervision or Assistance with Instrumental Activities of Daily Living

Beneficiaries may receive supervision or assistance in performing routine household tasks that may not require performance on a daily basis, but are essential for sustaining their health and welfare. **The purpose of providing assistance or support with these tasks is to meet the needs of the beneficiary, not the housekeeping needs of the beneficiary's household.** Assistance or support with IADL includes the following:

1. Light housekeeping, including the following:
    a. Vacuuming and mopping floors;
    b. Cleaning the bathroom and kitchen;
    c. Making the beneficiary's bed; or
    d. Ensuring pathways are free from obstructions.
2. Food preparation and food storage as required specifically for the beneficiary;
3. Shopping (with or without the beneficiary) for items specifically for the beneficiary including the following:
    a. Groceries;
    b. Personal hygiene items;
    c. Medications; or
    d. Other personal items.
4. Laundry of the beneficiary's clothing and bedding;
5. Medication reminders with self-administered prescription and non-prescription medication that is limited to the following:
    a. Verbal reminders;
    b. Assistance with opening the bottle or bubble pack;
    c. Reading the directions from the label;

d. Checking the dosage according to the label directions; or

e. Assistance with ordering medication from the drug store.

NOTE: Assistance does **NOT** include taking medication from the bottle to set up pill organizers, administering medications, and applying dressing that involves prescription medication and aseptic techniques of skin problems, unless the DSW has received the required training pursuant to La. R.S. 37:1031-1034.

6. Assistance with scheduling (making contacts and coordinating) medical appointments including, but not limited to appointments with the following:

   a. Physicians;

   b. Physical therapists;

   c. Occupational therapists; and

   d. Speech therapists.

7. Assistance in arranging medical transportation depending on the needs and preferences of the beneficiary with the following:

   a. Medicaid emergency medical transportation;

   b. Medicaid non-emergency medical transportation;

   c. Public transportation; and

   d. Private transportation.

8. Accompanying the beneficiary to medical appointments and provide assistance throughout the appointment.

Protective Supervision

Protective supervision may be provided to assure the health and welfare of a beneficiary who has cognitive or memory impairment or who has physical weakness as defined by the OAAS comprehensive assessment. The worker must be with the beneficiary and:

1. Be awake;

2. Be alert; and

3. Available to respond to the beneficiary's immediate needs.

Supervision or Assistance with Health-Related Tasks

Supervision or assistance with health-related tasks, as specified in the POC, may be provided to beneficiaries (any health related procedures governed under the Nurse Practice Act where the DSW has received the required training pursuant to La. R.S. 37:1031-1034). Supervision or assistance includes, but is not limited to, medication administration.

Supervision or Assistance while Escorting/Accompanying with Community Tasks

Supervision or assistance may be provided to beneficiaries while escorting or accompanying the beneficiary outside of the home to perform tasks, including IADL, health maintenance or other needs as identified in the POC, and to provide the same supervision or assistance as would be rendered in the home.

Extension of Therapy Services

Licensed therapists may choose to instruct attendants on the proper way to assist the beneficiary in follow-up therapy sessions to reinforce and aid the beneficiary in the rehabilitative process. The attendant may also be instructed by a RN to perform basic interventions with the beneficiary that would increase and optimize functional abilities for maximum independence in performing ADL such as range of motion exercise. Instruction provided by licensed therapists and RNs must be documented.

Shared Personal Assistance Services

PAS may be provided by one worker for up to three CCW beneficiaries who live together and have a common direct service provider (DSP). Beneficiaries receiving shared PAS must each be:

1. Approved to receive CCW;

2. Share the same residence; and

3. Have a common DSP.

Waiver beneficiaries may share PAS staff when agreed to by the beneficiaries, and the health and welfare of each beneficiary can be reasonably assured. Shared PAS is to be identified in the approved POC of each beneficiary. Reimbursement rates are adjusted accordingly. Due to the

requirements of privacy and confidentiality, beneficiaries who choose to share these services must agree to sign the "Release of Confidentiality for Shared PAS or LT-PCS" form to facilitate the coordination of services. (See Appendix B for a link to this form).

A.M. / P.M. Delivery Method

PAS may be provided through an "A.M. / P.M." delivery method. This delivery method provides PAS to the beneficiary at the beginning and/or end of the day.

PAS providers must be able to provide both regular and "A.M." and "P.M." PAS and cannot refuse to accept a CCW beneficiary solely due to the type of PAS delivery method that is listed on the POC.

Legally Responsible Individual/Spouse and Extraordinary Care Criteria

For purposes of the CCW program, a LRI is defined as a spouse who has a legal obligation, under state law, to care for another person. An LRI's legal (unpaid) obligation to care for the beneficiary includes routine care such as cooking/cleaning, regular family interactions and any legally indicated activities (medical/financial decisions).

Extraordinary care is defined as:

1. Activities which require an LRI/beneficiary's spouse to exceed the range of activities that would ordinarily be performed for an individual the same age without a disability/chronic illness; **AND**

2. Necessary to assure the health and welfare of the beneficiary and to avoid institutionalization.

The LRI/beneficiary's spouse, can **ONLY** be the PAS DSW for the CCW beneficiary, if **ALL** of the following conditions are met:

1. The current iHC assessment and/or beneficiary's POC indicates that the beneficiary has extraordinary health care needs **AND** extraordinary care is necessary:

    a. Extraordinary Health Care Needs Criteria - Beneficiary's behavioral, dementia related or nursing care needs as identified in the iHC assessment and/or the POC, such as but not limited to the following:

        i. Oxygen;

        ii. Tube feeding;

iii. Suctioning (this includes oropharyngeal, nasopharyngeal, and/or tracheal aspiration);

iv. Physical therapy (PT)/occupational therapy (OT);

v. Incontinence (with the use of urinary collection device* or ostomy);

vi. Stage four or non-codeable pressure ulcers;

vii. Dialysis; and/or

viii. Hospice.

*A urinary collection device is a catheter or other product that drains urine via tubing attached to a bag or container. Bed pans and hand held collection devices are not included.

b. Extraordinary Care Criteria - Beneficiary's lack of qualified support staff confirmed by:

i. The inability to locate or hire staff;

ii. Staff that apply are not able to provide the needed supports; and/or

iii. The spouse has a unique ability to meet the needs of the beneficiary (i.e. special skills, training, license that is tied to the support needed).

2. It is in the best interest of the beneficiary.

If OAAS determines that the LRI/spouse meets the "extraordinary" care criteria and the beneficiary meets the criteria for "extraordinary" health care needs, the LRI/spouse can serve as beneficiary's PAS DSW.

If the beneficiary believes that it is necessary for their spouse to be their worker, the beneficiary **MUST** inform their PAS DSP or self-direction employer.

The DSP or self-direction employer will complete the LRI/Spouse Request Form and email it to the OAAS RO for further review/processing. If additional information is needed, OAAS RO will request it from the DSP or self-direction employer. Once a final decision is made, OAAS RO will notify the DSP or self-direction employer and Fiscal/Employer Agent (F/EA) and the support coordinator.

If approved:

1. The support coordinator will document in the beneficiary's POC documentation;

2. The DSP will proceed with hiring the spouse as the worker per their usual hiring processes outlined in their licensing regulations; and

3. The self-direction employer/F/EA will proceed with hiring the spouse as the DSW per their usual hiring processes outlined in the OAAS CCW Self-Direction Employer Handbook and licensing regulations.

If NOT approved:

1. The support coordinator will contact the DSP or self-direction employer to ensure that they understand that the spouse **CANNOT** be the worker; and

2. The DSP or self-direction employer will need to find another worker that can meet the beneficiary's needs.

Service Exclusions

PAS providers may not bill for this service until after the individual has been approved for CCW.

PAS may not be billed at the same time of service as Adult Day Health Care (ADHC) and caregiver temporary support services (CTSS).

The beneficiary's responsible representative is prohibited from being the PAS worker.

Beneficiaries are not permitted to receive PAS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of their PAS provider. Furthermore, providers are prohibited from providing and billing for services under these circumstances. Beneficiaries may not live in the home of a DSW unless the DSW is related to the beneficiary and it is the choice of the beneficiary. These provisions may be waived with prior written approval by OAAS or its designee on a case-by-case basis.

NOTE: For more details and specifics on who can and cannot be the PAS DSW and who the beneficiary can and cannot live with, see Appendix B for the link to the "CCS PAS: DSW/Participant Relationship and Living Arrangements Guidance" document.

Service Limitations

There shall be no duplication of services.

PAS may not be provided while the beneficiary is admitted to a program or service that provides in-home assistance with ADL and/or IADL or while admitted to a program or setting where such assistance is provided (e.g. hospitals, nursing facilities, etc.). Therefore, PAS DSWs **CANNOT** receive payments on days that the beneficiary is admitted to a program or setting that provides ADL and/or IADL assistance. IADL may not be performed in the beneficiary's home when the beneficiary is absent from the home, unless it is approved by OAAS or its designee on a case-by-case basis.

The provision of PAS outside of the beneficiary's home does not include trips outside of the borders of the state without prior written approval by OAAS or its designee.

PAS cannot be provided or billed at the same hours on the same day as shared PAS.

Beneficiaries cannot receive PAS from the "A.M. / P.M." delivery method **on the same calendar day** as other PAS service delivery methods.

Beneficiaries utilizing the "A.M. / P.M." delivery method must be provided with at least one hour, but no more than two hours, of service during each session. If both the "A.M." and the "P.M." sessions are provided, there must be at least a four-hour break between the two sessions.

Shared PAS cannot be billed on behalf of a beneficiary who was not present to receive the service.

"A.M. / P.M." PAS cannot be shared.

A home health agency is limited to providing services within a 50-mile radius of its parent agency. This limit may be waived by the appropriate LDH authority on a case-by-case basis as needed.

Adult Day Health Care Services

ADHC services provide a planned, diverse daily program of individual services and group activities structured to enhance the beneficiary's physical functioning and to provide mental stimulation. ADHC services are furnished as specified in the POC at an ADHC center, in a licensed non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the beneficiary.

An ADHC center shall, at a minimum, furnish the following services in accordance with licensing regulations:

1. Training or assistance with ADL (toileting, grooming, eating, ambulation, etc.);

2. Health and nutrition counseling;

3. Individualized daily exercise program;

4. Individualized, goal-directed recreation program;

5. Health education;

6. Medical care management;

7. One nutritionally-balanced hot meal and a minimum of two snacks served each day;

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

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

   a. Monitoring vital signs appropriate to the diagnosis and medication regimen of each beneficiary no less frequently than monthly;

   b. Administering medications and treatments in accordance with physicians' orders;

   c. Developing and monitoring beneficiary's medication administration plans (self-administration and staff administered) of medications while the beneficiary is at the ADHC center; and

   d. Serving as a liaison between the beneficiary and the medical resources including the treating physician.

   NOTE: All nursing services shall be provided in accordance with professional practice standards and all other requirements identified in the ADHC licensing rules – Louisiana Administrative Code (LAC) Title 48: Part I. Subpart 3. Chapter 42. ADHC – "Nursing Services".

9. Transportation between the beneficiary's place of residence and the ADHC center at the beginning and end of the program day, which includes the following:

   a. The cost of transportation is included in the rate paid to ADHC centers. The beneficiary and their family may choose to transport the beneficiary to the

ADHC center. Transportation provided by the beneficiary's family is not a reimbursable service; and

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

b. Transportation to and from medical and social activities when the beneficiary is accompanied by ADHC center staff.

ADHC providers must adhere to the ADHC center requirements as outlined in the ADHC Licensing Rule – LAC Title 48: Part I. Subpart 3. Chapter 42. ADHC – Subchapter D. ADHC Center Services.

Service Exclusions

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

ADHC services may not be billed at the same time as PAS, monitored in-home caregiver (MIHC), home delivered meals (HDMs), and/or CTSS.

ADHC center attendance days shall not overlap with HDMs or medically tailored meals (MTMs).

Service Limitations

These services must be provided in the ADHC center that has been chosen by the beneficiary.

ADHC services are furnished on a regularly scheduled basis, not to exceed 10 hours per day, 50 hours per week (exclusive of transportation time to and from the ADHC center, as specified in the beneficiary's POC and ADHC individualized service plan (ISP)).

Caregiver Temporary Support Service

CTSS is furnished on a short-term basis because of the absence or need for relief of caregivers during the time they would normally provide unpaid care for the beneficiary. The purpose of CTSS is to provide relief to unpaid caregivers or principal caregivers of beneficiaries who receive MIHC services to maintain the beneficiary's informal support system. Federal financial participation is not claimed for the cost of room and board except when provided as part of CTSS furnished in a facility approved by the state that is not a private residence.

CTSS is provided in the following locations:

1. Beneficiary's home or place of residence;
2. Nursing facilities;
3. Assisted living facilities/adult residential care facilities;
4. Respite centers; or
5. ADHC centers.

CTSSs may be provided in the beneficiary's home by a Medicaid enrolled personal care attendant (PCA) or home health agency.

CTSSs that are provided by nursing facilities, assisted living, and respite centers must include an overnight stay.

CTSSs that are provided by an ADHC center may not be provided for more than 10 hours per day.

Service Exclusions

CTSS may not be delivered/billed at the same time as PAS or ADHC services.

Service Limitations

These services must be prior approved by the OAAS RO or its designee.

CTSS may be utilized for no more than 30 calendar days or 29 overnight stays per POC year, for no more than 14 consecutive days or 13 consecutive overnight stays.

These service limits may be increased based on documented need.

Monitored In-Home Caregiving Services

MIHC services are services provided to a beneficiary living in a private home with a principal caregiver. This service provides a community-based option of continuous care, supports, and professional oversight by promoting a cooperative relationship between the beneficiary, principal caregiver, professional staff of a MIHC provider, and the beneficiary's support coordinator. When beneficiaries plan to travel outside of Louisiana, there must be a written request (that includes a detailed explanation) submitted to OAAS or its designee at least 24 hours prior to the anticipated travel (when applicable).

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

1. Supervision or assistance in performing ADL;

2. Supervision or assistance in performing IADL;

3. Protective supervision provided solely to assure the health and welfare of a beneficiary;

4. Supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration;

5. Supervision or assistance while escorting/accompanying the beneficiary outside of the home to perform tasks, including IADL, health maintenance or other needs as identified in the POC and to provide the same supervision or assistance as would be rendered in the home; and

6. Extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or RN.

Providers capture daily notes electronically to monitor the beneficiary's health and the principal caregiver's performance. The daily notes must be available to support coordinators and LDH upon request.

Principal caregivers can be any of the following relations to the beneficiary:

1. Spouse;

2. Curator;

3. Tutor;

4. Legal guardian; or

5. Person to whom the beneficiary has given representative and mandate authority (also known as power of attorney).

Service Exclusions

Unless the individual is also the beneficiary's spouse, the beneficiary's responsible representative is prohibited from being the MIHC principal caregiver.

Service Limitations

Beneficiaries electing MIHC services are not eligible to receive the following CCW services during the period of time that the beneficiary is receiving MIHC services:

1. PAS; or

2. HDM services.

Beneficiaries can receive MIHC and ADHC services; however, MIHC and ADHC services **CANNOT** be received on the same day, in order to avoid duplication of services.

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

The provision of MIHC services outside of the borders of the state (e.g., temporary excursions, vacations, etc.) is prohibited without prior written approval by OAAS or its designee.

Assistive Devices and Medical Supplies

Assistive devices and medical supplies (ADMS) are specialized medical equipment and supplies that include the following:

1. Devices, controls, appliances, or nutritional supplements specified in the POC that enable beneficiaries to increase their abilities to perform ADL;

2. Devices, controls, appliances, or nutritional supplements specified in the POC to perceive, control, or communicate with the environment in which the beneficiary lives or to provide emergency response;

3. Items, supplies, and services necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items;

4. Supplies and services to assure beneficiaries' health and welfare, including pest control/eradication;

5. Other durable and non-durable medical equipment and necessary medical supplies that are not available under the Medicaid State Plan;

6. Personal Emergency Response System (PERS);

7. Other in-home monitoring and medication management devices and technology;

8. Routine maintenance or repair of specialized equipment; and

9. Batteries, extended warranties, and service contracts that are cost effective and assure health and welfare.

This includes medical equipment not available under the Medicaid State Plan that is necessary to address beneficiary functional limitations, and necessary medical supplies not available under the Medicaid State Plan that are included in the POC or other supporting documentation (e.g. assessment, support coordination documentation, etc.).

All costs associated with this service are subject to the beneficiary's annual budget allotment.

NOTE: Where applicable, beneficiaries must use Medicaid State Plan services, Medicare, or other available payers first. The beneficiary's preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

Personal Emergency Response System

PERS is an electronic device that enables the beneficiary to secure help in an emergency.

The unit is connected to the telephone line or a wireless communication device and is programmed to send an electronic message to a community-based 24-hour emergency response center when a "help" button is activated. This unit may either be worn by the beneficiary or installed in their home. It must meet Federal Communications Commission (FCC) standards or Underwriter's Laboratory standards or equivalent standards.

PERS services are appropriate for beneficiaries who are cognitively and/or physically able to operate the system. PERS is a measure to promote the health and welfare of the beneficiary.

The PERS unit shall be rented from the PERS provider.

The PERS must be checked monthly by the provider to ensure it is functioning properly. The PERS battery/unit must be checked once every quarter by the support coordinator during the home visit/quarterly virtual contact.

Telecare

Telecare is a delivery of care services to beneficiaries in their home by means of telecommunications and/or computerized devices to improve outcomes and quality of life, increase independence and access to health care, and reduce health care costs. Telecare services include the following:

1. Activity and sensor monitoring (ASM);
2. Health status monitoring (HSM); and
3. Medication dispensing and monitoring.

Monthly telecare services consist of the following:

1. Delivering, furnishing, maintaining, and repairing/replacing equipment on an ongoing basis. This may be done remotely as long as all routine requests are resolved within three business days;
2. Monitoring of beneficiary-specific service activities by qualified staff;
3. Training the beneficiary and/or the beneficiary's responsible representative in the use of the equipment;
4. Cleaning and storing equipment;
5. Providing remote teaching and coaching as necessary to the beneficiary and/or caregiver(s); and
6. Analyzing data, developing and documenting interventions by qualified staff based on information/data reported.

All telecare providers must make documentation collected from telecare services available to the support coordinator and OAAS upon request.

Activity and Sensor Monitoring

ASM is a computerized system that monitors the beneficiary's in-home movement and activity for health, welfare, and safety purposes. The system is individually calibrated based on the beneficiary's typical in-home movements and activities. The provider is responsible for monitoring electronically generated information, for responding as needed, and for equipment maintenance. At a minimum, the system shall include the following:

1. Monitor the home's points of egress;
2. Detect falls;
3. Detect movement or the lack of movement;
4. Detect whether doors are opened or closed; and
5. Provide a push-button emergency alert system.

The ASM system:

1. Is monitored by a call center;
2. Monitors the beneficiary's activity in the home; and
3. Learns the beneficiary's routines.

When the ASM system detects something out of the ordinary, the system generates messages to the beneficiary's list of identified caregivers. This system works through non-invasive sensors and motion detectors placed strategically around the home (e.g. in the bed, in the beneficiary's recliner in the living room, the kitchen door, exterior doors, the bathroom door, cabinet door containing medication, etc.) to ensure that the beneficiary's needs are being met, as well as the beneficiary's health and welfare. The placement of the sensors and/or monitors are based on the specific needs of the beneficiary as identified in the beneficiary's assessment and/or POC.

This service:

1. Only monitors the beneficiary's activity;
2. Decreases a beneficiary's one-on-one care; and
3. Assists the beneficiary in maintaining their independence so they may participate in community activities more easily.

NOTE: Some systems may also monitor the home's temperature.

Health Status Monitoring

The HSM service collects health-related data to assist the health care provider in assessing the beneficiary's health condition and in providing the beneficiary with education and consultation.

The data is collected electronically from the beneficiary using wireless technology or a phone line and assists the healthcare provider in assessing the beneficiary's health. HSM may be helpful to beneficiaries with chronic medical conditions such as congestive heart failure (CHF), diabetes, or pulmonary disease in monitoring the beneficiary's:

1. Weight;

2. Oxygen saturation measurements (pulse oximetry); and

3. Vital signs (pulse, blood pressure, etc.).

Peripheral equipment used must be capable of interfacing with the telecare HSM equipment.

Medication Dispensing and Monitoring

The medication dispensing and monitoring service assists the beneficiary by dispensing medication and monitoring medication compliance. A remote monitoring system is individually pre-programed to dispense and monitor the beneficiary's compliance with medication therapy. The provider or family caregiver is notified when there are missed doses or non-compliance with medication therapy.

Dispensing and monitoring devices must have the ability to send text or e-mail messages to the beneficiary's caregiver should the medication not be taken or there is a problem with the equipment.

Dispensing and monitoring systems may include a web-based component for dosage programming, monitoring, and/or communication.

Service Exclusions

No experimental items are allowed.

Service Limitations

The purchaser for assistive device/equipment purchases and/or medical supply purchases may be the beneficiary, the responsible representative, the DSP, the SCA, or any other source. However, only the SCA or the assistive devices provider can bill and be reimbursed for these services.

NOTE: The biller of this purchase(s) is not responsible for the interest accrued from the date of purchase(s) to the date of payment release.

Services must be based on a verified need of the beneficiary and the service must have a direct or remedial benefit with specific goals and outcomes.

The benefit must be determined by an independent assessment on any item that costs over $500 and on all communication devices, mobility devices, and environmental controls.

Independent assessments must be performed by individuals who have no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

All items must reduce reliance on other Medicaid State Plan or waiver services.

All items must meet applicable standards of manufacture, design, and installation.

The items must be on the POC developed by the support coordinator and are subject to approval by OAAS RO or its designee.

A beneficiary will not be able to simultaneously receive telecare ASM services and traditional PERS services.

Home Delivered Meals

HDMs assist beneficiaries in meeting their nutritional needs to support and maintain self-sufficiency and enhance their quality of life.

HDMs include up to two nutritionally balanced meals per day to be delivered to the home of a beneficiary who is:

1. Unable to leave the home without assistance;

2. Unable to prepare their own meals; and/or

3. Has no responsible caregiver in the home.

The HDM service is to provide the beneficiary a minimum of one-third of the current recommended dietary allowance (RDA) as adopted by the United States Department of Agriculture (USDA). The provision of HDMs does not provide a full nutritional regimen.

Meals are delivered to the beneficiary's home.

Service Exclusions

HDMs shall not overlap with ADHC services/center attendance days.

Service Limitations

HDMs are limited to two per day. It is permissible for beneficiaries to have some meals delivered daily and others delivered in bulk by different providers as long as the maximum of two meals per day is not exceeded. There is a maximum cost per meal. (See Appendix C for the link to the fee schedule).

HDM providers **CANNOT** bill HDMs on the days that the beneficiary attends the ADHC center.

Medically Tailored Meals

MTMs assists beneficiaries with certain chronic conditions in meeting their nutritional needs to support and maintain self-sufficiency and enhance their quality of life when they are discharging from the hospital and/or nursing facility.

MTMs includes up to two nutritionally balanced meals per day to be delivered to the home of a beneficiary who:

1. Has the following chronic conditions:
    a. CHF;
    b. Diabetes;
    c. Renal disease;
    d. Oral dysphagia;
    e. Gluten intolerance;
    f. Stroke;
    g. Chronic Obstructive Pulmonary Disease (COPD);
    h. Cancer; and/or
    i. Hypertension.
2. Is discharging from a hospital (from an inpatient admission) and/or nursing facility.

Beneficiaries may also receive nutritional counseling to support healthy food choices for their third meal and snacks.

MTMs provide the beneficiary a minimum of one-third of the current RDA as adopted by the USDA. The provision of MTMs does not provide a full nutritional regimen.

All MTMs are developed under the supervision of a registered dietician (RD)/registered dietician nutritionist (RDN)/licensed dietitian nutritionist (LDN) and must comply with the current Dietary Guidelines for Americans as published by the United States Department of Health and Human Services (DHHS) and the USDA, meet the current RDA/dietary reference intakes (DRI) established by the Food and Nutrition Board of Institute of Medicine of the National Academy of Sciences and follow current standards for specific diseases or conditions.

RD/RDN/LDN must be credentialed and in good standing with the Commission on Dietetics Registration.

Nutritional Counseling

Nutritional counseling provides supports to beneficiaries with certain chronic medical conditions (as identified above) via:

1. In-person;
2. By telephone; or
3. Telehealth.

This service provides guidance to beneficiaries, including but not limited to the following:

1. Healthy eating choices;
2. Healthy food options;
3. Reading food labels; and
4. Meal planning.

Beneficiaries may also receive nutritional counseling to support healthy food choices for their third meal (as MTMs are limited to two meals per day) and snacks.

Nutritional counseling must be provided by a:

1. RD;
2. RDN; or
3. LDN.

The nutritional counselor will complete an evaluation specific to the beneficiaries' medical diagnoses and a medically appropriate nutrition care plan that follow current standards for specific diseases or conditions.

Nutritional counselor(s) must be:

1. Licensed to practice in the state by the Louisiana Board of Examiners in Dietetics and Nutrition; and
2. Credentialed and in good standing with the Commission on Dietetics Registration.

Service Exclusions

MTMs shall not overlap with HDMs and/or ADHC center attendance days. Duplicate billing is not allowed.

Service Limitations

MTMs limitations include:

1. Two meals per day for up to 12 weeks beginning the first day of meal delivery after the beneficiary is discharged from a hospital or a nursing facility; and
2. No more than two 12 weeks of MTMs per POC year.

There is a maximum cost of MTMs per meal. (See Appendix C for the link to the fee schedule).

CCW beneficiaries receiving MIHC services cannot receive HDMs and MTMs/nutritional counseling.

Nutritional counseling services are limited to three sessions per 12 weeks of MTM home delivery post discharge from hospital or nursing facility. The maximum cost is $49.00 per nutritional counseling session.

MTMs/nutritional counseling is funded through American Rescue Plan Act (ARPA) funds and is NOT deducted from the beneficiary's annual POC budget.

Nursing

Nursing services are services that are medically necessary and may be provided efficiently and effectively by a nurse practitioner (NP), RN, or a licensed practical nurse (LPN) working under the supervision of an RN. Nursing services must be provided within the scope of the Louisiana Statutes governing the practice of nursing.

Nursing services may include periodic assessment of the beneficiary's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers.

Nursing services may also include regular, ongoing monitoring of a beneficiary's fragile or complex medical condition as well as the monitoring of a beneficiary with a history of noncompliance with medication or other medical treatment needs.

Nursing services may also be used to assess a beneficiary's need for assistive devices or home modifications/EAAs training the beneficiary and family members in the use of the purchased devices, and training of DSWs in tasks necessary to carry out the POC.

All services must be based on a verified need of the beneficiary and must have a direct or remedial benefit to the beneficiary with specific goals and outcomes.

Service Exclusions

Nursing care shall not be provided when the beneficiary is an inpatient at a hospital or in a nursing facility. Assessments are allowed. (See Appendix F for a list of concurrent services).

Service Limitations

Services must be approved by the OAAS RO or its designee and be prior authorized.

Services must be based on a verified need of the beneficiary.

Services must have a direct or remedial benefit to the beneficiary with specific goals and outcomes.

Where applicable, beneficiaries must use Medicare or other available payers first. The beneficiary's preference for a certain staff or agencies is not grounds for declining another payer

in order to access waiver services.

NOTE: Providers are not required to have a doctor's order for an assessment and treatment/service before this service is reimbursed by CCW. Providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.

Skilled Maintenance Therapy (Physical, Occupational, and Speech/Language)

Skilled maintenance therapy (SMT) includes PT, OT, and/or speech and language therapy that may be received by CCW beneficiaries in their home, work, or in a rehabilitative center/clinic.

SMT services provided to beneficiaries under the waiver are not necessarily tied to an episode of illness or injury and instead focus primarily on the beneficiary's functional need for maintenance of, or reducing the decline in, the beneficiary's ability to carry out ADL.

SMTs may also be used to assess a beneficiary's need for assistive devices or home modifications/EAAs, training the beneficiary and family members in the use of the purchased devices, performance of in-home fall prevention assessments, and participation on the POC planning team. Services may be provided in the beneficiary's home or in a variety of locations as approved by the POC planning team.

Physical Therapy

PT services promote the maintenance of, or reduction in the loss of, gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include:

1. Professional assessments;
2. Evaluations and monitoring for therapeutic purposes;
3. PT treatments and interventions;
4. Training regarding PT activities;
5. Use of equipment and technologies;
6. Designing, modifying or monitoring the use of related environmental modifications;
7. Designing, modifying, and monitoring the use of related activities supportive to the POC goals and objectives; or

8. Consulting or collaborating with other service providers or family members, as specified in the POC.

Occupational Therapy

OT services promote the maintenance of, or reduction in, the loss of fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology.

Specific services may include the following:

1. Teaching of daily living skills;
2. Development of perceptual motor skills and sensory integrative functioning;
3. Design, fabrication, or modification of assistive technology or adaptive devices;
4. Provision of assistive technology services;
5. Design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;
6. Use of specifically designed crafts and exercises to enhance function;
7. Training regarding OT activities; and
8. Consulting or collaborating with other service providers or family members as specified in the POC.

Speech Language Therapy

Speech language therapy services preserve abilities for independent function in communication, facilitate oral motor and swallowing function, facilitate use of assistive technology, and/or prevent progressive disabilities.

Specific services may include the following:

1. Identification of communicative or oropharyngeal disorders;
2. Prevention of communicative or oropharyngeal disorders;
3. Development of eating or swallowing plans and monitoring their effectiveness;

4. Use of specifically designed equipment, tools, and exercises to enhance function;
5. Design, fabrication, or modification of assistive technology or adaptive devices;
6. Provision of assistive technology services;
7. Adaptation of the beneficiary's environment to meet their needs;
8. Training regarding speech language therapy activities; and
9. Consulting or collaborating with other service providers or family members as specified in the POC.

Service Exclusions

Providers may not bill for services until after the individual has been approved for the CCW program and PA has been issued.

SMTs shall not be provided when the beneficiary is an inpatient at a hospital.

Service Limitations

Services must be based on a verified need of the beneficiary.

The service must have a direct or remedial benefit to the beneficiary with specific goals and outcomes.

NOTE: Where applicable, the beneficiary must use Medicare, Medicaid State Plan, or other available payers first. The beneficiary's preference for a certain therapist or agency is not grounds for declining another payer in order to access waiver services.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

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

Housing Transition or Crisis Intervention Services

Housing transition or crisis intervention services enable beneficiaries who are transitioning into a

permanent supportive housing unit, including those transitioning from institutions, to secure their own housing or provide assistance at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income). 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 living with someone else, accommodations needed, and other important preferences), and identifying the beneficiary's needs for support to maintain housing, including the following:

    a. Access to housing;

    b. Meeting the terms of a lease;

    c. Eviction prevention;

    d. Budgeting for housing/living expenses;

    e. Obtaining/accessing sources of income necessary for rent;

    f. Home management;

    g. Establishing credit; and

    h. Understanding and meeting the obligations of tenancy as defined in the lease terms.

2. Assisting the beneficiary to view and secure housing as needed. This may include the following:

    a. Arranging or providing transportation;

    b. Assisting in securing supporting documents/records;

    c. Assisting in completing/submitting applications;

    d. Assisting in securing deposits; and

    e. Assisting in locating furnishings.

3. Developing an individualized housing support plan based upon the housing assessment that meets the following criteria:

a. Includes short and long-term measurable goals for each issue;

b. Establishes the beneficiary's approach to meeting the goal(s); and

c. Identifies where other provider(s) or services may be required to meet the goal(s).

4. Participating in the POC development and incorporating elements of the housing support plan;

5. Looking for alternatives to housing if permanent supportive housing is unavailable to support completion of transition; and

6. Communicating with the landlord or property manager regarding the beneficiary's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.

If at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income), housing transition or crisis intervention 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.

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. Participating in the POC renewal and updates as needed to incorporate elements of the housing support plan;

2. Providing supports and interventions per the individualized housing support plan. If additional supports or services are identified as needed outside the scope of housing stabilization services, the needs must be communicated to the support coordinator;

3. Providing ongoing communication with the landlord or property manager regarding the following:

a. Beneficiary's disability;

b. Accommodations needed; and

c. Components of emergency procedures involving the landlord or property manager.

4. Updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status.

Service Exclusions

These services are only available upon referral from the support coordinator and are not duplicative of other waiver services, including support coordination. These services are only available to beneficiaries who are residing in, or who are linked for the selection process of, a State of Louisiana PSH unit.

Service Limitations

Up to 96 units of housing transition or crisis intervention service can be used per POC year without written approval from the support coordinator.

No more than 168 units of combined housing transition or crisis intervention services and housing stabilization services can be used per POC year without written approval from the support coordinator.

Assistive Technology

The assistive technology service is time limited, non-recurring and provides both an electronic device and an associated set-up visit to increase a beneficiary's access and participation in activities occurring within their home and the community. Devices purchased through the assistive technology service assist the participant in meeting POC goals, increasing communication, electronic visit verification (EVV) compliance, personal and professional interactions, leisure activities, outreach, and access to resources, support and medical care. The assistive technology service allows beneficiaries to purchase a device not otherwise covered by the Medicaid State Plan and receive a one-on-one face-to-face visit to set up and use the device.

The assistive technology service is comprised of the following mandatory components:

1. Electronic tablet device with internet capability that enable beneficiaries to:

   a. Perceive, control, or communicate within or outside of the beneficiary's residence; and

b. Increase access to services, resources and emergency response.

2. Screen protector and a case for the device designed to protect the item from damage; and

3. One-time set-up visit which includes:

   a. Delivery of the device;

   b. Device set-up and utilization; and

   c. In-person education and support provided directly to the beneficiary and/or the beneficiary's natural supports, responsible or legal representative, staff, or others that aid the beneficiary in the use of assistive technology equipment and set-up.

The identified need and how the needs will be addressed with the assistive technology must be included in the POC or POC Revision.

NOTE: For the beneficiary to receive assistive technology service, they must have internet service in the home.

This waiver service is funded through ARPA funds and is **NOT** deducted from the beneficiary's annual POC budget.

Service Exclusions

Assistive technology does not include:

1. Cost or reimbursement for an internet or data plan; and

2. Cost or reimbursement for repair or replacement of purchased devices or protective cases.

Service Limitations

There is a one-time lifetime maximum payment device/item(s) limit per beneficiary.

There is a one-time lifetime maximum procurement/set-up visit limit per beneficiary.

Services must be prior approved by OAAS or its designee and require PA.

Services must be based on a verified need of the beneficiary and the service must have a direct or remedial benefit with specific goals and outcomes. Devices must meet applicable standards of manufacture, design, and capability. The items must be on the POC developed by the support coordinator and are subject to approval by OAAS or its designee.

The purchaser for these items may be the beneficiary, the responsible representative, the DSP, the SCA, or any other source. However, the SCA is the **ONLY** source that can bill for these services.

This waiver service is not subject to the beneficiary's annual POC maximum allotment.

Financial Management Services

Financial Management Services (FMS) assists the beneficiary to live independently in the community while controlling their services by choosing the staff who work with them.

FMS are provided to beneficiaries who have chosen and are capable of self-directing their CCW PAS.

FMS are provided by a Medicaid enrolled F/EA and the F/EA's responsibilities and standards for participation are identified in LAC 50: Part XXI. Chapter 11, Subchapters A. through C.

Hospice and Waiver Services

Beneficiaries who elect hospice services may choose to elect CCW and hospice services concurrently. The hospice provider and SCA must coordinate CCW and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with CCW services.

When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's care giver and the SCA. The POC must clearly and specifically detail the CCW and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive services each day of the week.

The hospice provider must be licensed by LDH-Health Standards Section (HSS) and must provide all hospice services as defined in 42 Code of Federal Regulations (CFR) Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies, and counseling in accordance with hospice licensing regulations.

Once the hospice program requirements are met, then CCW PAS can be utilized for those personal care tasks with which the beneficiary requires assistance.

CCW services that have a personal care component associated with the service and are paid at a daily rate (e.g. MIHC, etc.) **CANNOT** be provided and billed on the same day as hospice services.

Waiver Services Payable While in a Nursing Facility

Certain CCW services are payable when transitioning from a nursing facility or for a beneficiary during a temporary stay in a nursing facility. (See Appendix F for a complete list of the CCW services).

SELF-DIRECTION OPTION

Self-direction is a voluntary service delivery option in the Community Choices Waiver (CCW) that allows beneficiaries to become the employers (rather than a licensed, enrolled provider as the employer) of the individuals they choose to hire to provide personal assistance services (PAS) to them. As the employers, beneficiaries, or their responsible representative, are responsible for recruiting, training, supervising, and managing the individuals they choose to hire.

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

Refer to the Fiscal/Employer Agent (F/EA) Manual for additional information. (See Appendix B for the link to this manual).

Support coordination services are also required for the development of the POC, budget planning, ongoing evaluation of supports and services, and for organizing the various resources the beneficiary needs. (See Appendix B for the link to the Office of Aging and Adult Services (OAAS) CCW Self-Direction Employer Handbook).

Beneficiaries participating in the self-direction option must:

1. Be certified for CCW services;

2. Be able to participate in this option without a lapse or decline in quality of care or an increased risk to health and welfare;

3. Complete the mandatory overview provided by the support coordinator;

4. Understand the rights, risks, and responsibilities of self-direction;

5. Manage and use an individual budget; and

   NOTE: If the beneficiary is unable to make decisions independently, they must have a willing decision maker (responsible representative) who understands the rights, risks, and responsibilities of managing the care and supports of the beneficiary within their individual budget.

6. Comply with all state and federal laws and regulations including but not limited to minimum wage and/or wage floor (whichever is the higher rate) and overtime requirements.

Termination of the Self-Direction Option

Termination from this option may be either voluntary or involuntary and the support coordinator will assist with the transition. A POC revision by the support coordinator is required in order to eliminate the F/EA and add the beneficiary's chosen Medicaid-enrolled direct service provider(s) (DSPs).

Beneficiaries who return to a traditional DSP must remain with this DSP for at least 90 calendar days (three months) before opting to return to the self-direction option if they are eligible to do so.

Beneficiaries may choose at any time to voluntarily return to a traditional DSP.

A beneficiary may be removed from self-direction and required to return to a traditional DSP if there are any violations of CCW or self-direction program rules.

BENEFICIARY REQUIREMENTS

The Community Choices Waiver (CCW) program is only available to individuals/beneficiaries who meet the following criteria:

1. Medicaid financial eligibility;

2. Age 65 years or older, **OR** 21 through 64 years of age with a physical disability that meets Medicaid standards or the Social Security Administration's disability criteria;

3. Nursing facility level of care (NFLOC) requirements;

4. Name on the CCW Request for Services Registry (RFSR); and

5. Plan of care (POC) sufficient to:

    a. Reasonably assure that the health and welfare of the waiver applicant can be maintained in the community with the provision of waiver services; and

    b. Justify that the CCW services are appropriate, cost effective and represent the least restrictive environment for the individual.

Failure of the individual to cooperate in the eligibility determination process or to meet any of the criteria above will result in denial of admission or discharge from CCW.

NOTE: An individual may only be certified to receive services from one home and community-based services (HCBS) waiver program at a time.

Community Choices Waiver Request for Services Registry

The Louisiana Department of Health (LDH) is responsible for the CCW RFSR, hereafter referred to as "the registry". An individual who wishes to have their name placed on the CCW registry shall contact a toll-free telephone number, which is maintained by the Office of Aging and Adult Services (OAAS).

Requests for CCW services shall be accepted from the following:

1. The applicant;

2. An individual who is legally responsible for the applicant; or

3. A responsible representative designated by the applicant to act on their behalf.

Individuals will be screened and/or assessed to determine whether they meet NFLOC and are members of the target population. Only individuals who meet these criteria will be added to the registry. The individual's name is placed on the registry in request date order.

NOTE: If at any time individuals do **NOT** meet NFLOC, their names will be removed from the OAAS registries (CCW registry and/or the Adult Day Health Care (ADHC) Waiver registry).

Priority Groups for Waiver Offers

CCW offers shall be presented to individuals on the registry according to priority groups. The following groups shall have priority in the order listed below:

1. Individuals with substantiated cases of abuse or neglect who are referred by Adult Protective Services (APS) or Elderly Protective Services (EPS) and who, without CCW services, would require institutional placement to prevent further abuse and neglect as determined by OAAS review;

2. Individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease;

3. Individuals who are residing in a state of Louisiana permanent supportive housing (PSH) unit or who are linked for the state of Louisiana PSH program;

4. Individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for their nursing facility stay;

5. Individuals who are not presently receiving HCBS under another approved Medicaid program, including, but not limited to the following:

    a. Program of All-Inclusive Care for the Elderly (PACE);

    b. Long-Term – Personal Care Services (LT-PCS); and/or

    c. Any 1915(c) Medicaid waiver programs.

6. All other eligible individuals on the registry, by date of first request for services.

If an applicant is determined to be ineligible for any reason at the time an offer is made, the next individual on the registry, based on the above stated priority group, is notified and the process continues until an individual is determined eligible.

Seventy-five CCW opportunities are reserved for individuals diagnosed with ALS. Qualifying individuals who have been diagnosed with ALS are offered one of these CCW opportunities on a first-come, first-served basis.

Expedited Waiver Opportunities

Up to 300 CCW opportunities may be granted to qualified individuals who require expedited CCW services. These individuals shall be offered a CCW opportunity on a first-come, first-served basis. To be considered for an expedited CCW opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of services allowable under the LT-PCS program and require institutional placement, unless offered an expedited CCW opportunity. The following criteria shall be considered in determining whether or not to grant an expedited CCW opportunity:

1. Support through other programs is either unavailable or inadequate to prevent nursing facility placement;

2. The death or incapacitation of an informal caregiver leaves the person without other supports;

3. The support from an informal caregiver is not available due to a family crisis;

4. The individual lives alone and has no access to informal support; or

5. For other reasons, the individual lacks access to adequate informal support to prevent nursing facility placement.

Admission Denial or Discharge Criteria

Failure of the individual to cooperate in the eligibility determination process or to meet any of the following criteria will result in denial of admission to or discharge from the CCW program:

1. The individual does not meet the target population criteria;

2. The individual does not meet the Medicaid eligibility criteria;

3. The individual does not meet NFLOC criteria;

4. The individual resides in another state or has a change of residence to another state;

5. Continuity of services is interrupted as a result of the beneficiary not receiving and/or refusing CCW services (exclusive of support coordination services) for a period of 30 consecutive days;

   NOTE: Continuity of services will not apply when interruptions are due to a beneficiary being admitted to an acute care hospital, rehabilitation hospital or nursing facility. This exception is granted by OAAS and will not typically exceed 90 consecutive days.

6. The health and welfare of the individual cannot be reasonably assured through the provision of CCW services;

7. The individual fails to cooperate in the eligibility determination process or in the development or performance of the POC;

8. The individual fails to maintain a safe and legal home environment; or

9. It is not cost effective to serve the individual in the CCW program.

NOTE: Individuals may be involuntarily discharged/transferred from the ADHC center. (Refer to LDH Medicaid ADHC Manual Section 9.2 – Admission Denial or Discharge Criteria).

BENEFICIARY RIGHTS AND RESPONSIBILITIES

Beneficiaries have specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs. Support coordination agencies (SCAs) and service providers must assist beneficiaries to exercise their rights and responsibilities. Every effort must be made to assure that applicants or beneficiaries understand their available choices and the consequences of those choices. SCAs and service providers are bound by their provider agreement with Medicaid to adhere to the following policies on beneficiary rights. (See Appendix B for the link to the "Office of Aging and Adult Services (OAAS) Rights and Responsibilities of Applicants/Participants of Home and Community-Based Services (HCBS) for Waiver" form).

Each individual who requests Community Choices Waiver (CCW) services has the option to designate a responsible representative to assist or act on their behalf in the process of accessing and/or maintaining CCW services. The beneficiary has the right to change their responsible representative at any time. The responsible representative may not concurrently serve as a responsible representative for more than two beneficiaries in a Medicaid HCBS program that is operated by the OAAS (unless an exception is granted by OAAS) which includes, but is not limited to:

1. Program of All-Inclusive Care for the Elderly (PACE);
2. Long-Term – Personal Care Services (LT-PCS);
3. CCW; and
4. Adult Day Health Care (ADHC) Waiver.

Freedom of Choice Program

Individuals who have been offered waiver services have the freedom to choose between institutional care services and HCBS. They are informed of their alternatives under the waiver at the time they are going through the Medicaid application and determination process. These individuals have the responsibility to participate in this process which includes providing medical and other pertinent information or assisting in obtaining this information to be used in the person-centered planning and service approval process. When applicants are admitted to the waiver, they have access to an array of Medicaid services.

Freedom of Choice Agencies/Providers

Beneficiaries have the freedom of choice (FOC) to select their SCA/providers. Beneficiaries may make agency/provider changes based on the following schedule:

Type of Service	Without Good Cause	With Good Cause
Transition Services Assistive Technology	Not applicable	Not applicable
Personal Assistance Services (PAS)	Every three months based on a calendar quarter	Any time
Support Coordination Transition Intensive Support Coordination (TISC)	Beneficiaries must have been with the agency at least six months	Any time
ADHC ADHC Health Status Monitoring (HSM)	Once every six months with the change effective beginning the first day of the following calendar quarter	Any time
Environmental Accessibility Adaptation (EAA) Skilled Maintenance Therapy (SMT) Nursing Assistive Devices and Medical Supplies (ADMS) Caregiver Temporary Support Service (CTSS) Home Delivered Meals (HDMs) Monitored In-Home Caregiving (MIHC) Services Housing Transition or Crisis Intervention Services and Housing Stabilization Services	Every six months	Any time

Financial Management Services (FMS)	Once every three months and the start date with the new Fiscal/Employer Agent (F/EA) must be at the beginning of the calendar quarter	Any time

Good cause is defined as:

1. A beneficiary moving to another region in the state where the current provider/agency does not provide services;

2. The beneficiary and the provider/agency have unresolved difficulties and mutually agree to a transfer;

3. The beneficiary's health or welfare has been compromised; or

4. The provider/agency has not rendered services in a manner satisfactory to the beneficiary.

Support coordinators will provide beneficiaries with the provider FOC list(s) and help arrange and coordinate all of the services on the plan of care (POC).

The OAAS, or its designee will provide beneficiaries with their choice of SCAs.

Adequacy of Care

All beneficiaries in HCBS waiver programs have the right to choose and receive the services necessary to support them to live in a community setting. Beneficiaries have the right to choose how, where, and with whom they live. Services are arranged and coordinated through support coordination services and approved by the OAAS Regional Office (RO) or its designee. If beneficiaries request a service and the support coordinator does not include that service in the POC, beneficiaries must contact the OAAS RO. Administrative limits are placed on some services according to the waiver document that is authorized and approved by the Center for Medicare and Medicaid Services (CMS).

Beneficiaries have the responsibility to request only those services that they need and not request excess services, or services for the convenience of employees, providers or support coordinators. Units of service are not "saved up". The services are certified as medically necessary for the beneficiary to be able to stay in the community and are revised on the POC as each beneficiary's needs change. The support coordinator must be informed any time there is a change in the beneficiary's health, medication, physical conditions, and/or living situation.

Participation in Care

Each beneficiary shall participate in the assessment and person-centered planning meetings and any other meetings involving decisions about services and supports to be provided as part of the waiver process. Each beneficiary may choose whether or not providers attend assessment and planning meetings. Person-centered planning will be utilized in developing all services and supports to meet the beneficiary's needs. By taking an active part in planning their services, the beneficiary is better able to utilize the available supports and services. The beneficiary is expected to participate in the planning process to the best of the beneficiary's ability so that services can be delivered according to the approved person-centered POC. The beneficiary shall report any service need change to their support coordinator and service provider(s).

Changes in the amount of services must be requested by the beneficiary and submitted to the support coordinator as soon as the need is identified. The support coordinator will prepare and submit the POC revision in accordance with the required timelines. Providers may not initiate a request for change/adjustment of service(s), or modifications to the POC, without the participation and consent of the beneficiary. OAAS RO or its designee must approve these changes.

Voluntary Participation

Beneficiaries have the right to:

1. Request services under the CCW program;
2. Refuse services;
3. Be informed of the alternative services available to them; and
4. Know the consequences of their decisions.

Therefore, a beneficiary will not be required to receive services or participate in activities that they do not want, even if they are eligible for these services. The intent of CCW is to provide HCBS to individuals who would otherwise require care in a nursing facility.

Providers must reasonably 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.

Quality of Care

Each HCBS waiver beneficiary has the right to be treated with dignity and respect and receive services from provider employees who have been trained and are qualified to provide them. In addition, providers are required to maintain privacy and confidentiality in all interactions related to the beneficiary's services.

Beneficiaries have the right to be free from the following types of abuse:

1. Mental;
2. Physical;
3. Emotional;
4. Coercion;
5. Restraints;
6. Seclusion; and
7. Any other forms of restrictive interventions.

In cases where services are not delivered according to the approved POC, or there are allegations of abuse, neglect, exploitation, or extortion, the beneficiary shall follow the reporting procedures and inform the support coordinator, provider, and appropriate authorities.

Beneficiaries and providers shall cooperate in the investigation and resolution of reported incidents/complaints.

Beneficiaries must:

1. Maintain a safe and lawful home environment;
2. Not request providers to perform tasks that are illegal or inappropriate;
3. Treat all provider's staff, including workers, and SCA's staff, including support

coordinators, with dignity and respect; and

4. Not violate the rights of other beneficiaries.

Civil Rights

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

Notification of Changes

The Bureau of Health Services Financing (BHSF)/Medicaid is responsible for determining financial eligibility for CCW beneficiaries. In order to maintain eligibility, beneficiaries and providers have the responsibility to inform BHSF/Medicaid of changes in the beneficiary's income, resources, address, and living situation.

OAAS or its designee is responsible for approving nursing facility level of care (NFLOC) and medical certification. Beneficiaries and their providers have the responsibility to inform OAAS of any changes which affect programmatic waiver eligibility requirements, including changes in level of care (LOC).

Grievances/Complaints

The beneficiary has a responsibility to bring problems to the attention of providers or the Medicaid program and to file a grievance/complaint without fear of retribution, retaliation, or discharge.

All SCAs and providers must have grievance procedures through which beneficiaries may voice complaints regarding the supports or services they receive. Upon admission, SCAs and providers must provide a copy of their complaint/grievance procedures to the beneficiary. Also, any time after admission, complaint/grievance procedures and forms shall be given to the beneficiaries upon request. It is the beneficiary's right to contact any advocacy resource as needed, especially during grievance procedures.

If beneficiaries need assistance, clarification, or to report a complaint, toll-free numbers are available. (See Appendix A for contact information).

Fair Hearings

Beneficiaries must be advised of their rights to appeal any agency action or decision resulting in suspension, reduction, discontinuance, or termination of services.

Beneficiaries have the right to a fair hearing through the Division of Administrative Law (DAL). In the event of a fair hearing, a representative of the service provider and SCA must participate by telephone, or in person, if requested.

An appeal by the beneficiary may be filed with the DAL via fax, mail, online request, or by telephone. (See Appendix A for DAL contact information). Instructions for submitting appeal requests are also included in all adverse action notices.

Rights and Responsibilities Form

The support coordinator is responsible for reviewing the beneficiary's rights and responsibilities with the beneficiary and/or their responsible representative as part of the initial intake process and at least annually, usually at the annual POC meeting, thereafter. (See Appendix B for information on accessing the "OAAS Rights and Responsibilities for Applicants/Participants of HCBS for Waiver" form).

SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Community Choices Waiver (CCW) opportunity or an existing opportunity is vacated, the individual who meets the criteria for one of the priority groups, or whose date is reached on the CCW Request for Services Registry (RFSR) shall receive a written notice indicating that a CCW opportunity is available. The applicant will receive a CCW offer packet that includes the following:

1. A CCW Services Decision form; and

2. A Support Coordination Agency (SCA) Freedom of Choice (FOC) and Release of Information form.

If the applicant is interested in accepting the CCW opportunity, they must complete and return the packet, selecting a SCA.

After the packet is returned, if the applicant meets the waiver offer criteria, they will be linked to a SCA. A support coordinator will be assigned to the applicant.

The support coordination must:

1. Conduct a face-to-face, in-home assessment with the applicant to determine medical eligibility;

2. Inform them of all available services under the CCW program; and

3. Assist the applicant as needed with the application process for Medicaid's determination of the financial eligibility process.

Once the assessment has been completed and it has been determined that the applicant meets the nursing facility level of care (NFLOC) requirements for the CCW program, the support coordinator may continue with the plan of care (POC) development. The POC development may be completed on the same day as the assessment or the support coordinator may schedule a second meeting to finalize the POC.

NOTE: The support coordinator may conduct the assessment and POC development at the same meeting, as long as the support coordinator has the equipment/capability to finalize the assessment and obtain the results while during the visit.

The following must be addressed in the POC:

1. Types and number of services (including waiver and all other services) necessary

to reasonably assure health and welfare and to maintain the beneficiary safely in the community;

2. Individual cost of each waiver service; and

3. Total cost of waiver services covered by the POC.

Provider Selection

The support coordinator must present the beneficiary with a list of providers who are enrolled in Medicaid to provide those services that have been identified on the POC. The support coordinator will have the beneficiary or responsible representative complete the provider FOC list. FOC will be offered initially, quarterly upon request, and annually thereafter for each identified waiver service.

The support coordinator is responsible for:

1. Notifying the selected providers that they have been chosen by the beneficiary to provide the necessary services;

2. Completing assessment and POCs;

3. Obtaining an agreement from the selected provider(s) to provide services;

4. Obtaining copies of any completed assessments and/or plans written by the Adult Day Health Care (ADHC) provider (if the beneficiary is receiving ADHC services); and

5. Forwarding the POC packet to the Office of Aging and Adult Services (OAAS) Regional Office (RO) or its designee for review and approval following the established protocol.

NOTE: Authorization to provide service is always contingent upon having an approved POC or POC revision.

Prior Authorization

All services under the CCW program must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid beneficiary by an enrolled Medicaid provider prior to service delivery and reimbursement. PA does not guarantee payment for the service as payment is contingent upon the passing of all 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.

The PA is generated by the data contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service.

The PA revolves around the POC document, which means that only the service codes and units specified in the approved POC will be prior authorized. Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

If the beneficiary is receiving ADHC services, the ADHC provider is responsible for developing an individualized service plan (ISP) in accordance with the approved POC and as stipulated in the ADHC licensing regulations and Medicaid certification rules (Louisiana Administrative Code (LAC) 50. XXI.2303 .A.).

The providers are responsible for the following activities:

1. Checking PAs to verify that all PAs for services match the approved services in the beneficiary's POC. Any mistakes must be immediately corrected;

2. Verifying that services were documented as specified in Section 7.8 – Record Keeping and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;

3. Verifying that services were delivered according to the beneficiary's approved POC prior to billing for the service;

4. Proper use of the electronic visit verification (EVV) system (if applicable);

5. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;

6. Billing only for the services that were delivered to the beneficiary and are approved in the beneficiary's POC;

7. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary (FI) with each payment; and

8. Checking billing records to ensure that the appropriate payment was received.

NOTE: Providers have one-year timely filing billing requirement under Medicaid regulations. See Section 1.4, Timely Filing Guidelines in the General Information and Administration Chapter of the Medicaid Services Manual at the following: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

Support Coordination

The data contractor issues authorizations for support coordination services for the POC year. A service unit is one month, and each authorization covers a maximum of seven months, or seven service units. Typically, two PAs will be issued for a one-year POC. At the end of the month, after the SCA fulfills the service requirements and inputs the required documentation in the data contactor's database, the data contractor will release one service unit of the PA.

Transition Intensive Support Coordination

Authorization for transition intensive support coordination (TISC) is issued upon receipt of the POC (provisional or initial).

A service unit is one month. The authorization includes a unit of service for each month with a maximum of six units of service per authorization. At the end of each month, after the SCA fulfills the service requirements and inputs the required documentation in the data contractor's database, the data contractor will release one service unit of the PA.

NOTE: Authorization for services will not be issued, retroactively, unless an individual leaving a facility is involved with special circumstances as determined and approved by OAAS.

Transition Services

Authorization for transition services has a lifetime cap of $1500. The authorization period is the effective date indicated on the POC or POC revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revision) that includes the transition services, the receipts for the purchases and the "Transition Services Form" are sent to the data contractor. (See Appendix B for the link to the copy of this form).

The data contractor issues and releases the PA to the SCA upon receipt of complete and accurate information. The SCA is responsible for reimbursing the purchaser (beneficiary, family, provider, own agency, etc.) upon receipt of reimbursement.

Environmental Accessibility Adaptation

When the data contractor receives a POC (provisional, initial or revision) that indicates a need for

an environmental accessibility adaptation (EAA), an authorization is issued for a basic assessment to the assessor. After the data contractor receives documentation that the assessor has completed the assessment, the PA for approval services is released.

If the basic assessment indicates the need for an EAA, the data contractor will issue the following two authorizations upon receipt of the POC revision:

1. Authorization for the final inspection and approval to the assessor; and

2. Authorization for the installation/completion of the EAA to the provider/contractor.

Upon receipt of documentation (either from the SCA or OAAS) that these tasks have been completed, the data contractor will release the PAs for payment.

Personal Assistance Services

An annual authorization of personal assistance services (PAS) is issued upon receipt of the POC (initial or revision). The authorization is based on the approved POC.

Units of service:

Type of Delivery Method	Unit of Service
A.M./P.M.	Per visit
Traditional	15 minutes

Approved units of service are calculated on a weekly basis to the provider and must be used for the specified week.

PAs are released on a daily basis after services are provided and documented in the EVV system. Units of service approved for one week cannot be combined with units of service for another week. For PA purposes, a week is defined as beginning at 12:00 A.M. Sunday and ending at 11:59 P.M. the following Saturday. Payment for services is capped for each week.

Unused portions of the prior authorized allotment may not be saved or borrowed from one week for use in another week.

NOTE: Beneficiaries receiving self-directed PAS should refer to the "OAAS CCW Self-Direction Employer Handbook." (See Appendix B for the link to this handbook).

Adult Day Health Care

ADHC service units are 15 minutes. ADHC services are assigned a PA number for the year. Approved units of service are issued on a quarterly basis. PAs are released after services are provided and documented in the EVV system. Units of service approved for one week cannot exceed established limits. For PA purposes, a week is defined as beginning at 12:00 A.M. Sunday and ending at 11:59 P.M. the following Saturday. Payment for services is capped at 50 hours per week and no more than 10 hours per day.

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

Caregiver Temporary Support Service

Authorization for caregiver temporary support service (CTSS) is issued for no more than 30 calendar days or 29 overnight stays per POC year. Each PA is capped at 14 calendar days or 13 overnight stays and no contiguous PAs are issued.

Units of service:

Type of Delivery Method	Unit of Service
In the home	15 minutes
Assisted Living Facility; Nursing Facility; Respite Care Center (ALL overnight)	Daily
ADHC center (not overnight)	15 minutes (maximum of 40 units/day)

PAs are released for personal care attendant (PCA) providers, ADHC centers and home health agencies after the service has been provided and documented in the EVV system.

Assisted living centers, nursing facilities and respite care centers use the data contactor's database to retrieve PAs, but do not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Monitored In-Home Caregiving Services

Authorization for monitored in-home caregiving (MIHC) services is issued upon receipt of the POC (initial, provisional, or revision).

Units of service:

Type of Delivery Method	Unit of Service
MIHC (Level One and Level Two services)	Per day
Intake and assessment	Per service

This provider type uses the data contactor's database to retrieve PAs, but does not utilize the database to document the provision of services.

The intake and assessment PA will be released once the MIHC Services Form is submitted to the data contractor by the support coordinator. "Per day" units may be billed using the proper PA, after services are delivered.

Assistive Devices and Medical Supplies

Authorization for assistive devices and medical supplies (ADMS) will be issued upon receipt of the POC (initial, provisional, or revision).

Units of service:

Type of Delivery Method	Unit of Service
Personal Emergency Response System (PERS) Installation Telecare Installation	One-time fee
PERS Maintenance Telecare Maintenance	Per month
Medication Dispensing and Monitoring	Per month
Equipment Rental and Repairs	Pay as approved
Equipment Purchase Medical Supply Purchase Procurement	Per service/Pay as approved

PERS installation and monthly units of service use the data contactor's database to retrieve PAs, but do not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

For all other "per month", "per service" or "pay as approved" units, the PA will be released for payment once the data contractor receives documentation from the support coordinator confirming the purchase/rental/repair/procurement. (See Appendix B for the link to the OAAS ADMS form).

Home Delivered Meals

Authorization for home delivered meals (HDMs) is issued according to the POC. The PA must be for a minimum of four meals per week, up to a maximum of 14 meals per week, not to exceed the limit of two meals per day. A service unit is one meal.

This provider type uses the data contactor's database to retrieve PAs, but does not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Medically Tailored Meals and Nutritional Counseling

Authorization for medically tailored meals (MTMs) and nutritional counseling services are issued according to the POC.

The PA for MTMs must be for 14 meals per week, not to exceed the limit of two meals per day. MTMs can begin the day after the beneficiary is discharged from the hospital or nursing facility and is not to exceed 12 weeks. A service unit is one meal.

The PA for nutritional counseling services are limited to three sessions per 12 weeks of MTM home delivery post discharge. A service unit is one nutritional counseling session/service.

This provider type uses the data contractor's database to retrieve PAs, but does not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Units of service:

Type of Delivery Method	Unit of Service
MTMs	Per service/meal
Nutritional Counseling	Per service

Nursing Services

A nursing service assessment and/or ongoing nursing services are authorized upon receipt of the POC (provisional, initial or revision).

Units of service:

Type of Delivery Method	Unit of Service
Assessment	Per service
Nursing Care	Per visit

Authorization is issued for no more than six months of service and in the amount indicated in the POC.

This provider type uses the data contactor's database to retrieve PAs, but does not utilize the database to document the provision of services. The PA will be released for payment once the data contractor receives the Nursing/Therapy Payment Authorization form from the support coordinator confirming the service/visit. (See Appendix B for the link to this form).

Skilled Maintenance Therapy Services (Physical Therapy, Occupational Therapy, Speech/Language Therapy)

A skilled maintenance therapy (SMT) assessment and/or ongoing therapy services are authorized upon receipt of the POC (provisional, initial or revision).

Units of service:

Type of Delivery Method	Unit of Service
Evaluation Re-evaluation	Per service
Therapy Home Care Training (Out-Patient)	Per Visit

Authorization is issued for no more than six months of service and in the amount indicated in the POC. The POC revision is based on the recommendations from the professional evaluation and as reflected on the CCW Nursing/Therapy Evaluation form. (See Appendix B for link to this form).

This provider type uses the data contactor's database to retrieve PAs, but does not utilize the database to document the provision of services. The PA will be released for payment once the data contractor receives the Nursing/Therapy Payment Authorization form from the support coordinator confirming the service/visit. (See Appendix B for the link to this form).

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

Authorization for these permanent supportive housing (PSH) services is made upon receipt of the POC (initial, provisional, or revision).

Units of service:

Type of Delivery Method	Unit of Service
Housing Stabilization	Per 15 minutes (maximum of 72 units per POC year)
Housing Transition or Crisis Intervention	Per 15 minutes (maximum of 96 units per POC year)

These provider types use the data contactor's database to retrieve PAs, but does not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Assistive Technology

Authorization for the assistive technology service is limited to a one-time lifetime purchase amount for the assistive technology device (including protective case for the device) and a one-time lifetime amount for the assistive technology procurement/set-up visit. The authorization period is the effective date indicated on the POC or POC revision through the POC end date. The POC or POC revision, including the applicable assistive technology services, is submitted to the data contractor. The data contractor issues a PA for the requested services placing a hold on the PA until verification of receipt of services. After the approved device purchase is made by the agency and the set-up visit completed, the POC/POC revision, the receipt(s) for the purchases and the Assistive Technology form are sent to the data contactor. (See Appendix B for the link to this form).

The data contactor issues and releases the PA to the SCA upon receipt of complete and accurate information.

Units of service:

Type of Delivery Method	Unit of Service
Purchasing Assistive Technology Device/Item(s)	Per service (one-time lifetime maximum payment)
Procurement for Set-Up Visit in the home	Per service (one-time lifetime maximum payment)

The PA will be released for payment once the data contactor receives documentation from the SCA confirming the purchase/set-up visit. The SCA is responsible for reimbursing the purchaser (beneficiary, family, provider, own agency, etc.) upon receipt of reimbursement. (See Appendix B for the link to OAAS Assistive Technology form).

Financial Management Services

Authorization for financial management services (FMS) will be issued upon receipt of the POC (initial, provisional or revision).

Units of service include the following:

Type of Delivery Method	Unit of Service
FMS Monthly Administrative Fee for the Self-Direction Option	Per month

This provider type uses the data contractor's database to retrieve PAs, but does not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Post Authorization

Some services require post authorization before the provider is able to bill for services rendered. Post authorization may occur either through EVV or through documentation submitted by the support coordinator as follows:

EVV	Additional Documentation
1. PAS 2. ADHC 3. CTSS (In-home)	1. SMTs 2. ADMS (excluding PERS) 3. Nursing Services

4. CTSS (ADHC and center based, not overnight)	4. MIHC - Intake and Assessment 5. Transition Services 6. EAA 7. Assistive Technology

The data contactor checks the information reported against the prior authorized units of service. Once post authorization is granted, the provider may bill the LDH FI for the appropriate units of service.

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

Changing Providers

Beneficiaries or their responsible representative must request any change in amount(s) of service/units directly to their support coordinator.

All requests for changes in providers require a new FOC by the beneficiary or their responsible representative. (Refer to 7.4 - Beneficiary Rights and Responsibilities, FOC of Providers, for details on "good cause" criteria and timelines).

The support coordinator will provide the beneficiary with the current FOC provider list for their region. Once a new provider has been selected, the support coordinator will ensure the new provider is notified of the request. Depending on the type of services being provided, and with written consent from the beneficiary, both the transferring provider and the receiving provider share responsibility for ensuring the exchange of medical and program information which includes the following:

1. Progress notes from the last six months, or if the beneficiary has received services from the provider for less than six months, all progress notes from date of admission;

2. Written documentation of services provided, including monthly and quarterly progress summaries (if applicable);

3. Current ISP, (if applicable);

4. Current assessments upon which the ISP is based, (if applicable);

5. A summary of the beneficiary's behavioral, social, health, and nutritional status, (if applicable);

6. Records tracking the beneficiary's progress towards ISP goals and objectives, (if applicable);

7. Documentation of the amount of authorized services remaining in the POC including direct service case record documentation; and

8. Documentation of exit interview.

The support coordinator will facilitate the transfer of the above referenced information to the receiving service provider and forward copies of the following to the new service provider:

1. Most current POC;

2. Current assessments on which the POC is based;

3. Number of services used in the calendar year; and

4. All other waiver documents necessary for the new provider to begin providing services.

NOTE: The new provider must bear the cost of copying the documents, which cannot exceed the community's competitive copying rate.

Prior Authorization for New Providers

The support coordinator will complete a POC revision that includes the start date for the new provider and the end date for the transferring provider. A new PA will be issued to the new provider with an effective starting date as indicated on the POC revision. The transferring provider's PA number will expire on the end date as indicated on the POC revision.

Changing Support Coordination Agency

A beneficiary(s) may request a change in their SCA through the support coordinator or by contacting OAAS RO. (Refer to 7.4-Beneficiary Rights and Responsibilities, FOC of Providers, for details on "good cause" criteria and timelines).

After the beneficiary has selected and been linked by the data contractor to a new SCA, the new agency must inform the transferring agency and complete the "Support Coordination Transfer of Records form". (See Appendix B for the link to this form). The new agency must obtain the case record and authorized signature from the transferring agency.

Upon receipt of the completed form, the transferring agency must have provided copies of the following information to the new agency:

1. Most current POC;
2. Current assessments on which the POC is based;
3. Number of services used in the POC year; and
4. Most recent (six months) of Support Coordination Contact Documentation (SCD) forms.

NOTE: The new SCA must bear the cost of copying the documents which cannot exceed the community's competitive copying rate. If the new agency does not receive the information in a timely fashion, the appropriate OAAS RO should be contacted for assistance.

The transferring SCA must provide services up to the transfer of records and is eligible to bill for support coordination services for the month in which the dated notification is received (transfer of records) by the receiving agency.

In the month the transfer occurs, the receiving agency must begin 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. Immediately after the transfer of records, the receiving agency must submit the required documentation to the data contractor to obtain PA.

Prior Authorization for New Support Coordination Agencies

A new PA number will be issued to the new SCA with an effective starting date as the first day of the first full calendar month following the date of the transfer of the records. The transferring agency's PA number will expire on the date of the transfer of the records.

OAAS or its designee will not backdate the new PA period to the first day of the calendar month in which the FOC and transfer of records are completed. If the new SCA receives the records and admits a beneficiary in the middle of a month, they cannot bill for services until the first of the next month.

PROVIDER REQUIREMENTS

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, including licensure, as established by state laws and rules promulgated by the Louisiana Department of Health (LDH);

2. Agree to abide by all rules, regulations, policies, and procedures established by the Centers for Medicare and Medicaid Services (CMS), LDH, and other state agencies, if applicable; and

3. Comply with all of the terms and conditions for Medicaid enrollment.

For detailed information concerning topics relative to Medicaid provider enrollment, providers should refer to Section 1.1 – Provider Requirements of the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

Providers must not:

1. Have been terminated or actively sanctioned by Medicaid, Medicare or any other health-related programs in Louisiana or any other state; and

2. Have an outstanding Medicaid program audit exception or other unresolved financial liability owed to the state.

Providers are required to:

1. Complete a criminal history and background check for all potential new employees, including supervisors;

2. Retain the results of the criminal history and background checks as documentation;

3. Not hire individuals that have criminal convictions preventing employment that are listed under 42 Code of Federal Regulations (CFR) 441.404(b) and listed in Louisiana Revised Statute (La. RS) 40:1203.1 et seq.;

4. Complete the following database checks for potential new employees, upon hire, and for current employees, on a monthly basis:

a. Louisiana State Adverse Actions List Search; and

b. Office of Inspector General (OIG) List of Excluded Individuals.

5. Retain the results of the database checks' print outs/documents as proof that the search was conducted; and

   NOTE: Regardless of the search results, the providers **MUST** keep the documentation that the search was conducted.

6. Not hire the individual as an employee or allow the employee to continue working for you, if their name appears on one of the database searches/lists.

   NOTE: For instructions and details on the database checks, please see Appendix G – Database Checks.

Failure to comply with all regulations may result in any or all of the following:

1. Recoupment;

2. Sanctions;

3. Loss of enrollment; and/or

4. Loss of licensure.

Providers and support coordination agencies (SCAs) must attend all mandated meetings and training sessions as directed by LDH and/or its designee as a condition of enrollment/certification and continued participation as a waiver provider or SCA.

A Provider Enrollment packet must be completed by the provider for each provider type and for each LDH administrative region in which the provider/agency will deliver services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number for that provider type.

Personal Assistance Services (PAS), Adult Day Health Care (ADHC), and caregiver temporary support services (CTSS) providers and SCAs (except for respite centers, nursing facilities, and adult residential care providers) must:

1. Participate in all training for prior authorization (PA) and data collection. Initial training is provided at no cost to the provider. Any repeat training must be paid for

by the requesting provider; and

2. Have available computer equipment software, and internet connectivity necessary to participate in PA, data collection, and Electronic Visit Verification (EVV).

All other providers must participate in the initial training for PAs and data collection and any training provided on changes in the system.

All brochures provided by the ADHC provider and SCAs must be approved by the Office of Aging and Adult Services (OAAS) prior to use.

Waiver services are to be provided strictly in accordance with the provisions of the waiver beneficiary's approved plan of care (POC). All providers and SCAs are obligated to immediately report to LDH any changes that could affect the waiver beneficiary's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

If the beneficiary is receiving ADHC services, the beneficiary's SCA and ADHC provider must have a written working agreement that includes the following:

1. Written notification of the time frames for POC planning meetings;

2. Timely notification of meeting dates and times to allow for provider participation;

3. Assurance that the appropriate provider representative is present at planning meetings as invited by the beneficiary; and

4. Information on how the agency is notified when a change occurs in the POC or service delivery.

SCAs and PAS providers are responsible for reporting critical incidents. For additional details regarding reporting requirements, procedures, and timelines see Appendix B for the link to the *OAAS Critical Incident Reporting Manual*.

ADHC providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety, and welfare of the beneficiary and completing an incident report. The incident report shall be submitted to the beneficiary's support coordinator with the specified requirements and timelines. (See Appendix B for the link to the *OAAS Critical Incident Manual*).

Each ADHC provider must complete the LDH approved cost report and submit the cost report(s) to the designated LDH contractor on or before September 30th following the close of the cost reporting period, which is July 1st – June 30th. (See Appendix A to obtain web address for additional information).

All other Community Choices Waiver (CCW) providers and support coordination agencies must complete the LDH approved cost report and submit the cost report(s) to the designated LDH contractor on or before November 30th following the close of the cost reporting period, which is July 1st – June 30th. (See Appendix A to obtain web address for additional information).

Licensure and Specific Provider/Agency Requirements

Providers and agencies, must meet licensure and/or certification and other additional requirements as outlined in the tables below and in other sections of this section:

Support Coordination, Transition Intensive Support Coordination, Assistive Technology, and Transition Services
Provided by a **SCA** that: 1. Is certified by LDH/OAAS to provide support coordination services; 2. Has signed the OAAS Performance Agreement; 3. Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training; 4. Has a brochure that has been approved by OAAS; 5. Has submitted a completed OAAS agency contact information form to OAAS; 6. Has enrolled as a Medicaid provider of support coordination services in all regions in which it intends to provide service; and 7. Is listed on the SCA FOC form.

Environmental Accessibility Adaptation
An Environmental Accessibility Adaptation (EAA) assessor must have, either through their own attainments or by contracting with other professionals: 1. Clinical expertise - licensed clinical personnel (i.e. physical therapist, occupational therapist, rehabilitation engineer, etc.); **AND** 2. Construction expertise - meet the requirements of EAA contractor (described

Environmental Accessibility Adaptation

below);

AND

3. Specialized certification – either the clinical or construction expert must have a specialized certification in Home Modification.

Specialized certification in Home Modification may consist of a supplemental certification through a licensed clinical professional's respective board, or, for the contractor, a comparable certification.

NOTE: Examples of acceptable certifications include, but are not limited to: Certified Aging in Place Specialist (CAPS), Executive Certificate in Home Modifications, Certified Environmental Access Consultant (CEAC).

EAA assessors must submit their enrollment packet to OAAS with documentation as specified in the Medicaid Provider Enrollment packet. (See Checklist in EAA Provider Enrollment packet).

OAAS will review entire packet and issue a letter of approval - provided that all requirements are met and documentation submitted. Once all requirements have been met, OAAS will forward the packet to Medicaid Provider Enrollment.

EAA Contractor Requirements

An EAA **Contractor** (**referred to as "EAA provider"**) must:

1. Have a general contractor, home improvement, or residential building license;

OR

2. Be a currently enrolled Louisiana Medicaid durable medical equipment (DME) provider with documentation from the manufacturing company (on that company's letterhead) confirming the DME provider is an authorized distributor of a specific product that attaches to a building, and this provider has been trained on its installation;

AND

3. Meet all state and/or local requirements (such as building contractors, plumbers, electricians, or engineers).

Environmental Accessibility Adaptation
NOTE: It is **NOT** permissible to be enrolled as both an EAA assessor and as an EAA provider. EAA providers shall not perform modifications beyond the scope of their state license or manufacturer authorization. **Both** EAA assessors and EAA providers must: 1. Obtain enrollment as either a Medicaid EAA assessor **or** provider; 2. Be listed as a provider of choice on the FOC form; 3. Comply with LDH rules and regulations; and 4. File claims in accordance with established Medicaid guidelines.
Personal Assistance Services
Provided by a **home health provider** that: 1. Is licensed to provide home health services; 2. Ensures their direct service workers (DSWs) meet Louisiana's minimum licensing standards as a qualified home health aide for home health agencies; and 3. Has enrolled in Medicaid to provide CCW PAS. **OR** Provided by a **personal care attendant (waiver) provider** that: 1. Has an home and community-based services (HCBS) provider license with the PCA module; and 2. Has enrolled in Medicaid as a PCA (waiver) service provider.

Adult Day Health Care

Provided by an **ADHC provider** that:

1. Is licensed by the LDH Health Standards Section (HSS) as an ADHC provider in accordance with La. RS 40:2120.47;
2. Has enrolled in Medicaid as an ADHC provider; and
3. Is listed on the ADHC FOC form.

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

Caregiver Temporary Support Services

Provided by a **personal care attendant (waiver) provider** that:

1. Has an HCBS provider license with the PCA module; and
2. Has enrolled in Medicaid to provide CTSS under the CCW.

OR

By a **home health provider** that:

1. Is licensed to provide home health services;
2. Is Medicare certified; and
3. Has enrolled in Medicaid as a caregiver temporary support provider.

OR

By a **respite center provider** that:

1. Is licensed according to La. RS 40:2101.1; and
2. Has enrolled in Medicaid as a caregiver temporary support provider.

OR

Caregiver Temporary Support Services

By an **ADHC provider** that:

1. Is licensed as an ADHC provider according to La. RS 40:2120.41-2120.47; and
2. Has enrolled in Medicaid as a caregiver temporary support provider.

OR

By a **nursing facility provider** that:

1. Is licensed as a nursing home according to La. RS 40:2009.1; and
2. Has enrolled in Medicaid as a caregiver temporary support provider.

OR

By an **adult residential care provider** that:

1. Is licensed according to La. RS 40:2166.1; and
2. Has enrolled in Medicaid as a caregiver temporary support provider.

Assistive Devices and Medical Supplies

Provided by an assistive devices provider that:

1. Has enrolled in Medicaid as an OAAS Waivers – assistive devices provider (provider type 17).

OR

Provided by a **DME provider** that:

1. Is enrolled to provide DME; and
2. Has enrolled in Medicaid as an OAAS Waivers - assistive devices provider (provider type 17);

OR

Assistive Devices and Medical Supplies

Provided by a **home health agency provider** that:

1. Is licensed to provide home health services;
2. Is Medicare certified; and
3. Has enrolled in Medicaid as an OAAS Waivers - assistive devices provider (provider type 17).

OR

Provided by a **Personal Emergency Response System (PERS)** provider that:

1. Has enrolled in Medicaid as a PERS provider (provider type 16); and
2. Has furnished verification (copy of letter from the manufacturer written on the manufacturer's letterhead stationary) that the provider is an authorized dealer, supplier or manufacturer of a PERS product.

OR

Provided by a **SCA** that:

1. Is certified by LDH/OAAS to provide support coordination services;
2. Has signed the OAAS Performance Agreement;
3. Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training;
4. Has a brochure that has been approved by OAAS;
5. Has submitted a completed OAAS agency contact information form to OAAS;
6. Has enrolled as a Medicaid provider of support coordination services in all regions in which it intends to provide service; and
7. Is listed on the SCA FOC form.

Home Delivered Meals, Medically Tailored Meals and Nutritional Counseling
Provided by a **home delivered meal (HDM) provider** that: 1. Is enrolled in Medicaid as a HDMs provider; and 2. **For in-state providers, including their subcontractors** - Has met all Louisiana Office of Public Health's (OPH's) certification permits and inspection requirements for retail food preparation, processing, packaging, storage, and distribution; **OR** 3. **For out-of-state providers** - Has met all of the United States Department of Agriculture (USDA) food preparation, processing, packaging, storage, and out-of-state distribution requirements. Permits and licenses must be issued by the state in operation.

Nursing
Provided by a **home health provider** that: 1. Is licensed to provide home health services; 2. Is Medicare certified; and 3. Has indicated a subspecialty inclusive of nursing when enrolled in Medicaid to provide CCW nursing services.

Skilled Maintenance Therapy – Physical Therapy, Occupational Therapy, or Speech/Language Therapy
Provided by a **home health provider** that: 1. Is licensed to provide home health services; 2. Is Medicare certified; 3. Has indicated subspecialties inclusive of physical therapy (PT), occupational therapy (OT) and/or speech/language when enrolled in Medicaid to provide CCW skilled maintenance therapy (SMT) services; and 4. Uses licensed therapists who have one full year of verifiable experience of working with the elderly.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services
Provided by a **permanent supportive housing service provider** that: 1. Agrees to serve any OAAS waiver beneficiary who qualifies for permanent supportive housing services (PSHS); 2. Is under contract and enrolled with LDH's Statewide Management Organization for Behavioral Services; 3. Has enrolled in Medicaid to provide CCW housing transition or crisis intervention services; and 4. Ensures that all agency employees who provide services have either completed the PSHS training provided by the state of Louisiana PSHS program or has at least a year of experience in the PSHS program as verified by the director of the PSHS program prior to providing services to waiver beneficiaries.

Monitored In-Home Caregiving Services
Provided by a **Monitored In-Home Caregiving (MIHC) services provider** that: 1. Has a HCBS provider license with the MIHC Module; 2. Is approved by OAAS to provide MIHC services; and 3. Has enrolled in Medicaid to provide MIHC services.

Financial Management Services
Provided by a **Financial Management Services (FMS) provider** that: 1. Completes the LDH's readiness review process and receives signed approval from the Bureau of Health Services Financing (BHSF) to move forward with provider enrollment; 2. Meets BHSF/OAAS insurance requirements; and 3. Has enrolled in Medicaid as a FMS provider.

Organized Health Care Delivery System
Provided by an **Organized Health Care Delivery System (OHCDS) provider** that: 1. Is a qualified and enrolled Medicaid provider who directly renders at least one of the following services offered in the CCW: PAS, HDMs, SMT, nursing, CTSS, assistive devices and medical supplies (ADMS), EAAs, or ADHC; 2. Shows the ability (either through its own employees or contracts with other qualified providers) to provide the above listed waiver services; contracting with ADHC is required only if there is an ADHC provider in the service area; 3. Has signed the OAAS OHCDS Provider Agreement; and 4. Has enrolled in Medicaid as an OHCDS provider.

Provider Responsibilities

CCW providers must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective licensing authorities and in accordance with all applicable LDH and OAAS rules and policies.

Providers must not refuse to serve any beneficiary who chooses their agency, unless there is documentation to support an inability to meet the beneficiary's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services.

Refusal to serve a beneficiary must be put in writing by the provider to the support coordinator and the beneficiary. This written notice must provide a detailed explanation as to why the provider is unable to provide services to the beneficiary. Upon receipt of this written documentation, the support coordinator is to forward the notice to the OAAS Regional Office (RO) for approval/refusal.

Providers shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to harassment, intimidation or threats against the beneficiary or members of the beneficiary's informal network, SCA staff or employees of LDH.

Providers must have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

If the provider proposes involuntary transfer of a beneficiary, discharge of a beneficiary or if a provider closes in accordance with licensing standards, the following steps must be taken:

1. Provider shall give written notice to the beneficiary, a family member and/or the responsible representative, if known, and the support coordinator at least 30 calendar days prior to the transfer or the discharge;

2. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the beneficiary understands;

3. Copy of the written discharge/transfer notice shall be put in the beneficiary's record; and

4. When the safety or health of beneficiaries or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge:

    a. Written notice shall include the following:

        i. Reason for the transfer or discharge;

        ii. Effective date of the transfer or discharge;

        iii. Explanation of a beneficiary's right to personal and/or third party representation at all stages of the transfer or discharge process;

        iv. Contact information for the Advocacy Center;

        v. Names of provider personnel available to assist the beneficiary and family in decision making and transfer arrangements;

        vi. Date, time, and place for the discharge planning conference;

        vii. Statement regarding the beneficiary's appeal rights;

        viii. Name of the director, current address, and telephone number of the DAL; and

        ix. Statement regarding the beneficiary's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include the following:

1. Developing a written report detailing the circumstances leading to any discharge;

2. Holding a transfer or discharge planning conference with the beneficiary, family, support coordinator, legal representative, and advocate, if such is known;

3. Developing a discharge plan that specifies the beneficiary's needed supports and resources available to them after discharge and includes options that will provide reasonable assurance that the beneficiary will be transferred or discharge to a setting that can be expected to meet their needs;

4. Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan up until the transfer or discharge; and

5. Coordinating and consulting with the receiving ADHC provider or other program (if applicable) to discuss the beneficiary's needs as warranted.

If the beneficiary is transferring or discharging from ADHC services, additional transfer or discharge responsibilities for the ADHC provider shall include the following:

1. Preparing and submitting to the receiving ADHC center or program an updated discharge service plan and written discharge summary of the beneficiary's needs and health that shall include, at a minimum:

    a. Medical diagnoses;

    b. Medication and treatment history/regimen (current physician's orders);

    c. Functional needs (inabilities);

    d. Any special equipment utilized (dentures, ambulatory aids, eyeglasses, etc.);

    e. Social data and needs;

    f. Financial resources; and

    g. Any other information which would enable the receiving ADHC center/caregiver(s) to provide the continued necessary care without interruption.

Support Coordination Agencies

SCAs must do the following:

1. Meet all of the requirements included in the OAAS support coordination performance agreement, the OAAS HCBS Waivers Support Coordination Standards for Participation rule and comply with all LDH and OAAS policies and procedures;

2. Maintain a toll-free telephone line with 24-hour accessibility manned by an answering service. This toll-free number must be given to beneficiaries at intake or at the first meeting with the beneficiary;

3. Maintain OAAS approved current brochures that provide information about the agency's experience providing support coordination services and includes the following information:

    a. That each participant has the FOC to choose their providers which does not affect eligibility for services;

    b. That a participant may contact the OAAS Help Line for information or questions regarding OAAS programs;

    c. Phone numbers for the OAAS Help Line phone number;

    d. Phone number(s) for the applicable OAAS ROs;

    e. The LDH HSS complaint line for submitting complaints against Support Coordinators, SCAs and Direct Service Providers (DSPs); and

    f. The agency's description, service(s) provided, current address and their local and toll-free number.

4. Complete timely revisions to the brochure, as requested by OAAS to reflect program changes and any other revisions deemed necessary by OAAS;

5. Provide adequate supplies of the agency's OAAS approved current brochures to OAAS or its designee;

6. Ensure staff attends all training mandated by OAAS;

7. Adhere to all National Voter Registration Act (NVRA) requirements. (Refer to the NVRA Manual – the link to this manual is located in Appendix B);

8. Furnish information and assistance to beneficiaries in directing and managing their services; and

9. Provide the beneficiary's approved POC to the providers in a timely manner.

If a beneficiary elects the option to self-direct their PAS, it is the support coordinator's responsibility to review the "OAAS-CCW Self-Direction Employer Handbook" with the beneficiary and be available for on-going support and assistance in these decision-making areas and with employer responsibilities.

For additional details on SCA responsibilities, procedures, and timelines, refer to Appendix B for the hyperlink to the "OAAS Waiver Procedures Manual for ROs and SCAs".

Environmental Accessibility Adaptation Providers

Providers are required to ensure that all modifications, adaptations, additions or repairs are made in accordance with all of the local and state housing and building codes, and must meet the Americans with Disabilities Act requirements.

There are two types of EAA providers:

1. **EAA Assessors** are responsible for the initial Home Assessment Evaluation (HAE), final inspection, and interim inspections (if needed); and

2. **EAA Contractors** (referred to as **EAA providers**) are responsible for completing actual construction and/or structural modification(s) based on the specifications provided by the EAA assessor.

Environmental Accessibility Adaptation Assessor

Upon referral from the support coordinator, the applicable professional(s) on staff or under contract must conduct a thorough assessment of the waiver beneficiary's functional needs and environment to do the following:

1. Identify (if applicable) any DME or assistive device/technology that could meet the beneficiary's needs;

2. Determine whether or not there is a need for structural modification/environmental adaptation to the home; and

3. Complete a written HAE report to include the following:

    a. Detailed description of the findings;

    b. Recommendations to satisfy the identified needs of the beneficiary;

    c. Justification for any construction/structural modification recommendations rather than alternatives such as DME, assistive technology , etc.;

    d. Specifications for any recommended construction/structural modifications;

    e. Cost estimates for each type of recommendation; and

    f. Signatures of each member of the EAA assessor's team (staff/contractors, etc.) who participated in the evaluation.

In addition, the EAA assessor will be required to do the following:

1. Perform inspections as needed throughout the process; and

2. Perform a final inspection to ensure that all specifications have been met.

EAA Providers

Upon selection by the beneficiary, the EAA provider shall do the following:

1. Review the written HAE report submitted by the EAA assessor;

2. Provide a written bid based on specifications in the EAA assessor's report. The bid must include actual cost with labor and materials listed separately;

3. Complete the adaptation in accordance with the signed agreement/contract;

    NOTE: If, for any reason before or during the process, the EAA provider believes it necessary to deviate from the specifications provided in the EAA assessor's written report, the EAA provider must first contact the EAA assessor and request a change to the Assessor's HAE report and specifications before proceeding. The EAA assessor may exercise discretion in approving such requests.

4. Offer warranty on the service and/or product; and

5. Assume responsibility for the costs associated with bringing the work up to standard, including but not limited to materials, labor and costs of any subsequent inspections should the work not be completed according to specifications.

Personal Assistance Service Providers

A home health agency's DSW who renders PAS must be a qualified home health aide as specified in Louisiana's *Minimum Standards for Home Health Agencies* licensing regulations.

When permissible, family members who provide PAS must meet the same standards for employment as caregivers who are unrelated to the beneficiary. (See PAS Service Exclusions in Section 7.1).

Every PAS provider shall ensure that each beneficiary who receives service from their agency has a written back-up staffing plan in the event the assigned worker is unable to provide support due to unplanned circumstances or emergencies which may arise during that DSW's shift. If the provider cannot meet the beneficiary's needs, the provider must submit "good cause" reasons to the OAAS RO.

In all instances when a DSW is unable to provide support due to unplanned circumstances, including emergencies which arise during a DSW's shift, the DSW must contact the provider and family/beneficiary immediately. Actions shall then be taken according to the beneficiary's "Back-Up Staffing Plan". (See Appendix B for the link to a copy of this form).

Back-Up Staffing Plan

PAS providers must do the following:

1. Discuss available options for back-up coverage and complete the "Back-Up Staffing Plan" with the beneficiary or responsible representative;

2. Obtain all names, telephone numbers of contacts and signatures/verbal agreement of any family/natural supports responsible for emergency coverage;

3. Sign and date the form;

4. Submit the form to the beneficiary's SCA within five business days of being selected as the PAS provider;

   NOTE: If the SCA does not receive this form within five business days, the

beneficiary will be instructed to select another provider.

5. Assess on an ongoing basis whether the "Back-Up Staffing Plan" is current and being followed according to plan; and

6. Collaborate with the beneficiary or responsible representative, support coordinator, OAAS RO and protective services when applicable, to assure that all back-up staffing difficulties are resolved appropriately.

Emergency Plan

SCAs must complete the "Emergency Plan" in a timely manner for each beneficiary they serve in accordance with OAAS policy.

PAS providers must cooperate to ensure timely completion of the "OAAS Emergency Plan" for each waiver beneficiary they serve. (See Appendix B for the link to this form).

PAS providers must do the following:

1. Collaborate with the beneficiary's support coordinator as required for completion of the "Emergency Plan"; and

2. Sign and return the form to the SCA within five business days of receipt, or give verbal agreement, indicating responsibility accepted for designated tasks on the form.

   NOTE: If the SCA does not receive this form within five business days, the beneficiary will be instructed to select another PAS provider.

If the emergency plan is activated, the PAS provider's director bears responsibility for performance of those tasks agreed to in the plan.

Adult Day Health Care Providers

ADHC providers must have written policy and procedure manuals that include, but are not limited to the following:

1. Administrative: Employment and personnel job descriptions; hiring practices including a policy against discrimination; employee evaluation, promotion, disciplinary action, termination and hearing of employee grievances; staffing and staff coverage plan;

2. Employment Qualifications: Must possess direct care abilities, skills and knowledge to adequately perform care and assistance as required by waiver beneficiaries;

3. Training: Staff orientation in safety and emergency procedures as stipulated by LDH licensing and certification rules and regulations;

4. Records: Maintenance, security, supervision, confidentiality, organization, transfer and disposal;

5. Beneficiary Rights: Identification, notification and protection of beneficiary's rights both verbally and in writing in a language the beneficiary/family is able to understand;

6. Grievances: Written grievance procedures;

7. Abuse/Neglect: Information about abuse and neglect as defined by LDH regulations and state and federal laws; reporting responsibilities;

8. Discharges: Voluntary and involuntary discharges/transfers from their center; and

9. Electronic Visit Verification (EVV): Requirements/proper use of check in/out; acceptable editing of electronically captured services; confidentiality of log in information; and monitoring for proper use.

ADHC providers must do the following:

1. Comply with all applicable LDH rules and regulations including the use of an approved EVV system;

2. Provide transportation to any beneficiary within their licensed region in accordance with ADHC licensing standards;

NOTE: An ADHC center may serve a beneficiary residing outside of the ADHC's licensed region; however, the ADHC center is not required to provide transportation. ADHC centers are required to offer transportation to beneficiaries within their licensed region, but no beneficiary, irrespective of their place of origin, may be transported for longer than one hour on any individual trip.

3. Provide the beneficiary's approved individualized service plan (ISP) to the support coordinator in a timely manner.

ADHC providers are not allowed to impose that beneficiaries attend a minimum number of days per week. A beneficiary's repeated failure to attend as specified in the POC may warrant a POC revision, or a possible discharge from the ADHC service and/or the CCW program. ADHC providers should notify the beneficiary's support coordinator when a beneficiary routinely fails to attend the ADHC as specified.

When an ADHC provider reaches licensed capacity, the ADHC provider must notify OAAS RO immediately. The ADHC center name will be removed from the ADHC FOC form until the ADHC provider notifies OAAS RO that they are able to admit new beneficiaries.

An ADHC center shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the ADHC provider's responsibilities are carried out and that the following functions are adequately performed:

1. Administrative;
2. Fiscal;
3. Clerical;
4. Housekeeping, maintenance and food service;
5. Direct services;
6. Supervision;
7. Record-keeping and reporting;
8. Social services; and
9. Ancillary services.

The ADHC provider shall ensure the following:

1. All non-licensed direct care staff members meet the minimum, mandatory qualifications and requirements for DSWs as required by La. RS 40:2179-2179.1;
2. All staff members are properly certified and/or licensed as legally required;
3. An adequate number of qualified direct service staff is present with beneficiaries as necessary to ensure the health and welfare of beneficiaries;

4. Procedures are established to assure adequate communication among staff in order to provide continuity of services to beneficiaries to include:

    a. Regular review of individual and aggregate problems of beneficiaries, including actions taken to resolve these problems;

    b. Sharing daily information, noting unusual circumstances and other information requiring continued action by staff; and

    c. Maintenance of all accidents, injuries, and incident records related to beneficiaries.

5. Employees working with beneficiaries have access to information from case records necessary for effective performance of the employees' assigned tasks;

6. A staff member who has knowledge of and can apply first aid and who is certified in cardiopulmonary resuscitation (CPR) must be in the ADHC center at all times;

7. A staff member who is designated to supervise the ADHC center in the absence of the director;

8. A written plan of emergency and safety procedures that includes training staff on their duties when responding to emergencies and evacuating beneficiaries to safe or sheltered areas; and

9. All furnishings and equipment are:

    a. Kept clean;

    b. In good repair; and

    c. Appropriate for use by the beneficiaries in terms of comfort and safety.

Each ADHC provider shall ensure that its setting is integrated in and supports full access to the greater community including the option to seek employment in integrated settings if desired, engaging in community life, and to receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

Caregiver Temporary Support Services Providers

CTSS providers must comply with LDH rules and regulations and be listed as a provider of choice

on the FOC form as a CTSS provider prior to providing service.

Monitored In-Home Caregiving Service Providers

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

1. Be agency providers who employ professional nursing staff and other professionals to train and support principal caregivers to perform the direct care activities performed in the home;

2. Assess and approve the home in which services will be provided;

3. Enter into contractual agreements with caregivers who they have approved and trained; and

4. Pay per diem stipends to principal caregivers.

Assistive Devices and Medical Supply Service Providers

Assistive devices providers and SCAs that provide certain ADMS must meet the following:

1. Comply with LDH rules and regulations;

2. Be enrolled in Medicaid to provide these services; and

3. Be listed as a provider of choice on the FOC form.

PERS providers must meet the following:

1. Comply with OAAS' standards for participation;

2. Be enrolled as the applicable Medicaid provider type; and

3. Be listed as a provider of choice on the FOC form.

The PERS provider must install and support PERS equipment in compliance with all of the applicable federal, state, parish, and local laws and regulations, as well as meet manufacturer's specifications, response requirements, maintenance records, and beneficiary education.

Assistive devices providers and other enrolled providers that provide telecare services under ADMS, must meet the following system requirements:

1. Be UL listed/certified or have 501(k) clearance;

2. Be web-based;

3. Be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);

4. Have beneficiary specific reporting capabilities for tracking and trending;

5. Have a professional call center for technical support based in the United States; and

6. Have on-going provision of web-based data collection for each beneficiary, as appropriate. This includes response to beneficiary self-testing, manufacturer's specific testing, self-auditing, and quality control.

Home Delivered Meal Providers

All in-state providers must meet all of the Louisiana OPH certification, permit and inspection requirements for retail food preparation, processing, packaging, storage, and distribution.

All out-of-state providers must meet retail food preparation, processing, packaging, storage, and distribution requirements of the USDA and the state of operation.

All providers must be enrolled in Medicaid and comply with LDH rules and regulations.

Nursing Providers

Providers must be enrolled in Medicaid as a nursing provider, comply with LDH rules and regulations, and must be listed as a provider of choice on the FOC form.

Nursing services provided must be within the scope of the Louisiana Statutes governing the practice of nursing.

Nursing services may be provided by a nurse practitioner (NP), a registered nurse (RN) or licensed practical nurse (LPN) employed by a home health agency. Providers of nursing services must also ensure that licensed nurses have received orientation on waiver services and adhere to the requirements in the *OAAS Critical Incident Reporting Manual*. (See Appendix B for the link to this manual).

Skilled Maintenance Therapy Providers

SMT services may be provided by home health agencies that employ licensed therapists and comply with LDH rules and regulations.

Providers are not required to have a doctor's order for assessments or treatment/services before this service is reimbursed through the CCW program; however, providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.

Housing Transition or Crisis Intervention Service Providers and Housing Stabilization Service Providers

Housing transition or crisis intervention services and housing stabilization services providers must be enrolled in Medicaid to provide these services, comply with LDH rules and regulations, and be listed as a provider of choice on the FOC form.

Providers of housing transition or crisis intervention services and providers of housing stabilization services must comply with the Louisiana PSHS program's critical incident reporting requirements and procedures. (See Appendix B for the link to the "PSHS Policies and Procedure Manual").

Providers must ensure the housing assessment is current and is performed at least annually.

Providers must cooperate and work closely with the beneficiary's support coordinator to ensure all housing issues are adequately planned for and addressed.

Assistive Technology Service Providers

Assistive technology services must be provided by SCAs.

The assistive technology devices purchased for the beneficiary must meet the following requirements:

1. Have internet capability;

2. Contain security features (locking, passwords, etc.) that are compliant with the requirements of HIPAA;

3. Be either iOS or Android system based;

4. Have a minimum screen size of 10 inches;

5. Have a minimum of 32GB storage capacity; and

6. Include a shockproof full body protective cover/case and screen protector.

Financial Management Services Providers

FMS must be certified through the completion of LDH's readiness review process and receives signed approval from BHSF to move forward with provider enrollment.

FMS providers must meet BHSF/OAAS insurance requirements and meet the standards for participation as set forth in LAC 50:XXI.Chapter 11. Subchapters A-C.

Providers must be enrolled in Medicaid as an FMS provider, comply with LDH rules and regulations, and sign a performance agreement with LDH.

Provider Changes

For ADHC providers, the following changes must be reported in writing to the HSS, OAAS and the fiscal intermediary's (FI's) Provider Enrollment Section, within five business days of the actual change:

1. Name of the ADHC center;

2. Physical location;

3. Mailing address;

4. Contact information (i.e. telephone number, fax number, email address); and

5. Key administrative staff (e. director, program manager, social service designee, RN/ LPN, etc.).

When a change of ownership (CHOW) occurs, the ADHC provider shall notify HSS in writing within 15 calendar days prior to the effective date of the CHOW.

For all HSS licensed providers, the following changes must be reported in writing to HSS, OAAS and the FI's Provider Enrollment section within the time specified in the HSS licensing rule:

1. Provider's entity name ("doing business as" name);

2. Key administrative personnel;

3. Ownership;

4. Physical location;

5. Mailing address;

6. Telephone number; and

7. Account information affecting electronic funds transfer (EFT).

When a CCW provider closes or decides to no longer participate in the Medicaid program, the provider must give at least a 30 calendar day written advance notice to all beneficiaries served and their responsible representatives, SCAs, and LDH (OAAS and HSS – if licensed) prior to discontinuing service.

RECORD KEEPING

Providers should refer to the Medicaid Services Manual, Chapter 1 – General Information and Administration, Section 1.1 - Provider Requirements for additional information of record keeping at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

NOTE: For this section, the term "provider" refers to either the Home and Community-Based Services (HCBS) provider or the support coordination agency (SCA).

Components of Record Keeping

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

A separate record that supports justification for prior authorization (PA) and fully documents services for which payments have been made must be maintained on each beneficiary. The provider must maintain sufficient documentation to enable LDH, or its designee, to verify that prior to payment each charge is due and proper. The provider must make available all records that LDH or its designee, including the beneficiary's SCA, finds necessary to determine compliance with any federal or state law, rule or regulation promulgated by LDH.

Retention of Records

The provider must retain administrative, personnel and beneficiary records for a minimum of six years from the date of the last payment period. If records are under review as part of a departmental or government audit, the records must be retained until all audit questions are answered and the audit is completed (even if that time period exceeds six years).

NOTE: Upon provider closure, all provider records must be maintained according to applicable laws, regulations, and the above record retention requirements and copies of the required documents must be transferred to the new provider.

Confidentiality and Protection of Records

Records, including administrative and beneficiary, must be the property of the provider and secured against loss, tampering, destruction, or unauthorized use.

Employees of the provider must not disclose or knowingly permit the disclosure of any information

concerning the provider, the beneficiaries or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the beneficiaries or their families.

The information may be released only under the following conditions:

1. Court order;

2. Beneficiary's written informed consent for release of information;

3. Written consent of the individual to whom the beneficiary's rights have been devolved when the beneficiary has been declared legally incompetent; or

4. Compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 Code of Federal Regulations (CFR), Part 2).

A provider must, upon request, make available information in the case records to the beneficiary or legally responsible representative. In the professional judgment of the administration of the agency, if it is felt that information contained in the record would be damaging to the beneficiary, that information may be withheld from the beneficiary, except under court order.

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

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

Any electronic communication containing beneficiary specific identifying information sent by the provider to another provider, or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system.

Beneficiary records must be located at the enrolled site.

NOTE: Under no circumstances should providers allow staff to take beneficiary's case records from the provider's site, including the Adult Day Health Care (ADHC) center.

Review by State and Federal Agencies

Providers must make all administrative, personnel, and beneficiary records available to LDH or its designee and appropriate state and federal personnel within the specified timeframe given by LDH or its designee. Providers must always safeguard the confidentiality of beneficiary information.

Beneficiary Records

Providers must have a separate written record for each beneficiary served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, SCAs and service providers must have on-going adequate chronological documentation of activities/services offered and provided to the beneficiaries they serve.

Records at the Beneficiary's Home

Personal Assistance Services (PAS) providers must maintain the following documents at the beneficiary's home:

1. Current copy of the beneficiary's plan of care (POC) and POC revision (if applicable); and

2. Copies of the beneficiary's service logs for the current prior authorized week. (A prior authorized week begins on Sunday at 12:00 A.M. and ends on the following Saturday at 11:59 P.M.).

   Example: If LDH staff or designee goes into the home on a Wednesday, service logs for that day, along with the applicable documentation (if services were performed) from that Sunday, Monday, and Tuesday (the current prior authorized week) are required.

   NOTE: The link for the "Community Choices Waiver (CCW) PAS Log" along with instructions for using and completing this form can be found in Appendix B.

LDH or its designee may request additional records from the provider. Records should be made available to the requestor in accordance with LDH policy.

See tables below for specific information regarding documentation of the following services:

Support CoordinationAgencies and Transition Intensive Support Coordination Services	
Monthly Contacts	Complete each calendar month at the time of the monthly monitoring contact according to the Office of Aging and Adult Services (OAAS) documentation and data entry requirements.
Interim Contacts	Complete at the time of interim activities, according to OAAS documentation and data entry requirements.
Quarterly Contacts	Complete each calendar quarter at the time of the quarterly monitoring contact according to OAAS documentation and data entry requirements.
Annual Contacts	Complete in the last month of the POC year at the time of the annual monitoring contact, according to OAAS documentation and data entry requirements. **NOTE:** The annual monitoring may be performed at the same time as the monthly monitoring or at another time during the last month of the POC year.
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Transition Services Providers	
Receipts/Cancelled Checks	Document deposits, set-up fees, or items purchased and reimbursement made to purchaser(s) if outside of SCA.
Transition Services Form (TSF)	Complete to obtain applicable approval for PA.

Environmental Accessibility Adaptation Providers	
Assessment	Completed by assessor with recommendation (either Environmental Accessibility Adaptations (EAA) job or alternative).
Itemized Bid(s)	Completed by provider when EAA job is recommended.

Personal Assistance Service Providers	
Service Log	Complete task checklist after each activity has been performed and/or supports have been provided. Page two of the service log (progress notes) is to be completed as applicable to reflect observed changes and other important information about the beneficiary. (Refer to Appendix B for form/instructions).
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Adult Day Health Care Providers	
Attendance Log	Complete daily with date and time of arrival and date and time of departure. **NOTE:** An electronic visit verification (EVV) system generated report satisfies this requirement.
Progress Notes	Complete at least weekly **and** when there is a change in the beneficiary's condition or routine.
Progress Summary	Complete at least every 90 calendar days.
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Skilled Maintenance Therapy Providers	
Assessment	Complete at time of activity.
Progress Notes	Complete within 10 calendar days of service activity.
Progress Summary	Complete at least every 90 calendar days or as specified in the POC.
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Nursing Services Providers	
Assessment	Complete at time of activity.
Progress Notes	Complete within 10 calendar days of service activity.
Progress Summary	Complete at least every 90 calendar days or as specified in the POC.
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Home Delivered Meals, Medically Tailored Meals, and Nutritional Counseling Providers	
Copy of Invoice	Document delivery of the home delivered meals (HDMs) or medically tailored meals (MTMs) to the home, including number of meals shipped, date of mailing, and price per unit.
	Document delivery of nutritional counseling session/service, copy of evaluation and nutritional meal plan, date of service/session and price per unit.

Caregiver Temporary Support Services Providers	
Service Log	Refer to Appendix B for form/instructions.

Monitored In-Home Caregiving Services Providers	
Daily Electronic Notes	Sent via secure web-based exchange documenting delivery of services and overall condition; sent daily.

Assistive Devices and Medical Supply Providers	
Copy of Invoice	Document device and/or medical supplies provided including price per unit.
Training on use of Device/Equipment	Document training provided to the beneficiary and/or representative on the service, use, maintenance, and safety of the device/equipment.
Telecare & Personal Emergency Response System (PERS) Monitoring,	Maintain clinical documentation of all service activities, data, and all beneficiary contacts.

Maintenance and Contact	

Permanent Supportive Housing Providers	
***Progress Notes**	Complete at the time of activity.
Case Closure/Transfer	Complete within 14 calendar days of discharge.
Housing Needs Assessment	Initially and annually thereafter; revise and update as needed

*Refer to Appendix B for information on accessing the CCW Permanent Supportive Housing Services (PSHS) progress note form. Providers are not mandated to use this particular form; however, all elements contained in this form are required to support billing for these services. The use of any Progress Note form other than the one provided in Appendix B must be approved by OAAS or its designee prior to use.

Assistive Technology Providers	
Receipts/Cancelled Checks	Document items purchased (device, screen protector and case) and reimbursement made to purchaser(s), if outside of SCA.
Set-Up Visit	Maintain the documentation provided to the participant at the set-up visit.

Financial Management Services Providers	
Beneficiary Record	Separate record for beneficiary that fully documents financial management services (FMS) for which payments have been made. (Refer to Chapter 3 – Fiscal/Employer Agent (F/EA) for specific record keeping requirements).
Case Closure/Transfer	Complete within 14 calendar days of discharge.

LDH or its designee may request additional records from the provider. Records shall be made abailable to the requestor in accordance with LDH policy.

Organization of Records, Record Entries, and Corrections

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

All entries and forms completed by staff in beneficiary records must be legible, written in ink (if not completed electronically) and include the following:

1. Name of the person making the entry;
2. Signature of the person making the entry;
3. Functional title of the person making the entry;
4. Full date of documentation; and be
5. Reviewed/signed by the supervisor, if required.

Any error made in a beneficiary's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" along with the correction by it and the initials of the person making the change**. Correction fluid must NEVER be used in a beneficiary's records**. The provider's office staff **CANNOT** change any of the documentation entered by the worker.

Service Logs

OAAS PAS logs, also referred to as "Service Logs," document PAS or caregiver temporary support services (CTSS) (in the home) that are provided and billed. These service logs are the "paper trail" for services delivered by the worker. (See Appendix B for the link to this required form and the associated instructions).

CTSS (in the home) providers are to write "OAAS-CCW CTSS" on the top of the service log and document all PAS and non-PAS tasks and comments in the "progress note" space.

Service logs contain the following information:

1. Name of beneficiary;
2. Name of provider and employee providing the service;

3. Date of service contact; and

4. Content of service contact.

NOTE: The start and stop time of service contacts (PAS, CTSS (in the home), and ADHC), as well as the location where check in/check out occurs, are captured through the use of an EVV system.

A separate service log must be kept for each beneficiary. Reimbursement is only payable for services documented on the service log. PAS and CTSS (in the home) providers are required to use the standardized weekly OAAS service log (OAAS-PF-11-015) for documentation of CCW PAS and CTSS (in the home).

All portions of the service log must be completed each week. Photocopies of previously completed service logs will **NOT** be accepted.

Service logs must be:

1. Completed **daily as tasks are performed**. (Service logs may not be completed prior to the performance of a task); and

2. Signed and dated by the worker and by the beneficiary or responsible representative **AFTER the work has been completed at the end of the week**.

Progress notes are located on the second page of the service log and are the means of documenting the following:

1. Observed changes in the beneficiary's mental and/or medical condition(s), behavior or home situation that may indicate a need for a reassessment and POC, and/or individualized service plan (ISP) change as applicable; and

2. Other information important to ensure continuity of care.

Examples of when to document in a narrative progress note include but are not limited to:

1. Provided more assistance than what is indicated in the POC due to the beneficiary's request or their increased need; and

2. Assistance not provided with a particular task/subtask as indicated in the POC due to beneficiary's request or their lack of need.

When progress notes are written/entered, they must meet the following:

1. Be legible;
2. Include the date of the entry;
3. Include the name of the person/worker making the entry; and
4. Be completed and updated in the record in the time specified.

Each provider's documentation should support justification for PA or payment of services. Services billed must clearly be related to the current approved POC and ISP, if applicable.

NOTE: Services logs (including the progress notes section) can be completed, signed, initialed, and/or dated electronically, as long as the provider complies with all service log requirements identified in this manual, as well as the State and HIPAA requirements. If providers use an electronic version of the service log, it must be identical to the approved OAAS service log.

For specifics on ADHC services/ADHC providers, refer to the LDH Medicaid ADHC Waiver Manual Section 9.6 – Record Keeping – Progress Notes and Summaries for ADHC services.

Transfers and Closures

The following providers must complete/enter a progress note in the beneficiary's record when a case is transferred or closed for the following CCW services:

Name of Service	Provider Type
Support Coordination	SCA
Transition Intensive Support Coordination (TISC)	SCA
ADHC	ADHC provider
PAS	Personal Care Attendant (PCA) provider; Home Health Agency provider; or Fiscal Agent
CTSS	CTSS provider; PCA provider; or Center-Based Respite provider
Monitored In-Home Caregiving (MIHC)	MIHC provider
Nursing Services	Home Health Agency provider

Skilled Maintenance Therapy (SMT)	Home Health Agency provider
PSHS	PSHS Agency provider
FMS	Fiscal Agent provider

A discharge summary must include the following:

1. Be entered in the beneficiary's record and detail the beneficiary's progress prior to a transfer and/or closure;

2. Be sent to the individual, or provider/agency responsible for the future planning and care of the beneficiary; and

3. Be completed within 14 calendar days following a beneficiary's discharge.

REIMBURSEMENT

Reimbursement for Community Choices Waiver (CCW) services vary based on the type of service being provided. Providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. (Refer to Appendix C in this manual chapter for information about procedure code, unit of service, and current reimbursement rate).

Reimbursement shall not be made for CCW services provided prior to approval of the plan of care (POC) and release of prior authorization (PA) for the services.

The CCW program is the payer of last resort in accordance with federal regulation 42 Code of Federal Regulations (CFR) 433.139. Failure by the provider to exhaust all third-party payer sources may subject the enrolled agency/provider to recoupment of funds previously paid by Medicaid. Third parties include, but are not limited to, private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds, and Medicare.

The claim submission date cannot precede the date the service was rendered.

Refer to Appendix D of this manual chapter for information about claims filing.

Support Coordination

Support coordination services are reimbursed at an established monthly rate. (See Appendix C – Billing Codes). The data contractor issues a monthly authorization to the support coordination agency (SCA). After the support coordination requirements are met and documented in the data contractor's database, the authorization is released to the SCA. For each quarter in the beneficiary's POC year, if the SCA does not meet all of the requirements for documentation in the case management database, the PA for the last month of that quarter will not be released until all requirements are met and the "Request for Payment/Override Form" has been completed and submitted to the Office of Aging and Adult Services (OAAS) Regional Office (RO) for approval.

Transition Intensive Support Coordination

Transition Intensive Support Coordination (TISC) services are reimbursed at an established monthly rate, for a maximum of six months (not to exceed 180 calendar days) from the POC approval date so long as the beneficiary is residing in the nursing facility. (See Appendix C – Billing Codes). Payment will not be authorized until the data contractor receives an approved POC indicating that the individual was/is a nursing facility resident during the period in which the PA is requested.

Transition Services

Transition services are reimbursed only for the exact amount of expenditures indicated on final approval and supporting documentation. Only one authorization for transition services is issued. The authorization period is the effective date of the POC or POC revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial, or revision) that includes the transition services, the receipts for the purchases, and the "Transition Services Form (TSF)" are sent to the data contractor. (See Appendix B for a copy of this form).

The SCA is then notified of the release of the authorization and can bill the Medicaid fiscal intermediary (FI) for these expenses. If the SCA did not initially pay for the pre-approved transition expenses, the SCA shall reimburse the actual purchaser within 10 calendar days of receipt of reimbursement.

The OAAS RO, or its designee, shall maintain documentation, including each individual's TSF with original receipts and copies of canceled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes.

Billing for transition services must be completed within 60 calendar days after the individual's actual move date in order for the reimbursement to be paid.

NOTE: If the individual is not approved for CCW services and/or does not transition, but transition service items were purchased, the OAAS RO must notify the OAAS State Office to allow for possible reimbursement.

If it is determined that additional items are needed after the TSF was approved, and there are remaining transition funds in the individual's budget, the support coordinator must submit another TSF within 90 calendar days after the individual's actual move date. The same procedure outlined above shall be followed for any additional needs.

NOTE: If it is determined that the individual has additional needs that were not identified, or billing was not able to occur, within the above established timelines, the OAAS RO must notify OAAS State Office to review for exception.

Environmental Accessibility Adaptation

Environmental Accessibility Adaptation (EAA) services are reimbursed in the amount authorized in the POC or POC revision. The EAA assessor must approve the completion of the modification prior to the provider submitting billing. If for some reason the EAA assessor is unable to perform this function, the OAAS RO must provide approval prior to the provider submitting billing. The PA is released upon completion and submission of the EAA form by the support coordinator.

Personal Assistance Services

Personal assistance services (PAS) providers are reimbursed at an per quarter-hour-rate for services provided under a prospective payment system (PPS) that recognizes and reflects the cost of direct care services provided.

Release of PA for PAS is contingent on post authorization. Post authorization occurs through the Electronic Visit Verification (EVV) system. EVV is mandatory for PAS. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OAAS. The system is to be used to electronically "check in" and "check out" when the PAS worker begins and when they end service delivery for a participant.

While there may be some circumstances that require manual edits by the provider's designee, these should only be occasional. In the event that there is a billing overlap, the provider that uses the EVV system correctly (i.e. data has not been manually added or edited) will have priority for payment.

Providers who are approved to provide services to more than one beneficiary under shared PAS must bill separately for each beneficiary based on their POC. Each beneficiary must be present to receive the shared services in order for the provider to bill for the service.

Adult Day Health Care

Adult Day Health Care (ADHC) providers are reimbursed at a per quarter-hour-rate for services provided under a PPS that recognizes and reflects the cost of direct care services provided.

The use of the EVV system is mandatory for ADHC services. The EVV system requires use of LaSRS® or another EVV system approved by BHSF and OAAS. The system is to be used to electronically "check in" and "check out" waiver participants when they arrive and when they leave the ADHC center. While there may be some circumstances that require manual edits, these should only be occasional.

The transportation component of ADHC is exempt from this mandatory EVV requirement. However, using the EVV system to electronically record when beneficiaries get on/off the ADHC transportation vehicle may be beneficial to the ADHC provider in preventing overlaps with in-home services and for cost reporting.

In the event of an overlap, the provider that uses the EVV system (i.e. data has not been manually added or edited) will have priority for payment.

Caregiver Temporary Support Services

For providers of overnight Caregiver Temporary Support Services (CTSS), the PA start date will be the morning after the first night of service, and the PA end date will be the morning after the last night of service. Providers may bill for the service after the service has been delivered.

In-home, ADHC, and center based caregiver temporary support (not overnight) requires post authorization through EVV.

Monitored In-Home Caregiving

Reimbursement for the monitored in-home caregiving (MIHC) intake and assessment is based on a set fee. The PA is released once the MIHC Services form has been completed and submitted to the data contractor by the support coordinator.

Reimbursement for daily MIHC services is based upon a two-tiered model based on the results of the beneficiary's assessment.

Tier Level	RUG III/HC Categories
Tier 1	Special Rehabilitation 1. 111 2. 121 3. 122
	Special Care 1. 320
	Clinically Complex 1. 411 2. 421
	Cognitive Impairment 1. 510
	Behavior Problem 1. 610
	Physical Function 1. 710 2. 720
Tier 2	Extensive Special Care 1. 210 2. 220

Tier Level	RUG III/HC Categories
	3. 230
	Special Care 1. 310

The MIHC provider may bill for services after service delivery.

Assistive Devices and Medical Supplies

Reimbursement for the Personal Emergency Response System (PERS) is based on a set installation fee and a monthly maintenance fee. The PERS provider may bill for services after they are delivered.

Reimbursement for Telecare services includes a one-time installation fee that covers the cost of equipment installation and removal. A monthly maintenance fee includes a face-to-face visit by a qualified professional should the collected data warrant a visit. Should the beneficiary require additional visits during the month, those visits must be conducted by a nurse, authorized by the support coordinator, and provided under Nursing Service. If the data indicates a potential emergency, the provider may dispatch a qualified professional without consultation for approval with the support coordinator; however, the support coordinator must be contacted by the next business day to request retroactive approval.

Billing for PERS or Telecare services involves an installation fee and a monthly maintenance fee. Only one claim for each month is allowed. Claims for the monthly maintenance fee may be span-dated at the discretion of the provider. Partial months shall not be billed.

If a beneficiary who receives PERS or Telecare service moves to a different location or changes providers, reimbursement for a second installment is permissible.

Assistive devices and medical supplies (ADMS) (up to $500) are reimbursed in the amount authorized in the POC or POC revision. The PA is released upon completion and submission of the SDMS form and the approved POC or POC revision by the support coordinator.

If the ADMS purchase cost will exceed $500, OAAS RO must review and approve the purchase. The PA is released upon completion and submission of the ADMS form and the approved POC or POC revision by the support coordinator.

ADMS procurement is reimbursed in the amount authorized in the POC or POC revision. The PA

is released upon completion and submission of the ADMS form and the approved POC or POC revision by the support coordinator.

Home Delivered Meals

Reimbursement for home delivered meals (HDMs) must not exceed the set rate. The provider uses the PA to bill for services after the meals have been delivered.

Providers may span date bill for up to a two week supply of meals.

Medically Tailored Meals and Nutritional Counseling

Reimbursement for medically tailored meals (MTMs) and nutritional counseling must not exceed the set rates and the 12 week maximum limits. For MTMs, the provider uses the PA to bill for services after the MTMs have been delivered to the home. For nutritional counseling, the provider uses the PA to bill for services after the counseling session occurred.

Providers may span date bill for up to a two week supply of MTMs.

Nursing Services

Providers of nursing services are reimbursed at a set rate per visit. The support coordinator will complete and submit the Nursing/Therapy Payment Authorization Form to the data contractor after verifying that the services were delivered. The PA will then be released for payment, and the provider may submit billing using the proper PA.

Skilled Maintenance Therapy

Providers of skilled maintenance therapy (SMT) are reimbursed at a set rate per visit. The support coordinator will complete and submit the Nursing/Therapy Payment Authorization Form to the data contractor after verifying that the services were delivered. The PA will then be released for payment, and the provider may submit billing using the proper PA number.

Housing Transition/Crisis Intervention Services and Housing Stabilization Services

These services are reimbursed at a set rate and in the amount authorized in the approved POC or POC revision. The provider may bill the Medicaid FI using the proper PA after services have been provided.

Assistive Technology

Assistive technology services are reimbursed as noted below:

1. For the device: only the exact amount of expenditures indicated on the final approval and supporting documentation (receipts); and

2. For the procurement/set-up visit: a one-time lifetime maximum payment.

Only one authorization for assistive technology services is issued. The authorization period is the effective date of the POC or POC revision request through the POC end date.

After the approved device purchases are made and the in-person set-up visit is completed, the POC or POC revision, the receipt(s) for the purchases and the "Assistive Technology Form" are sent to the data management contractor. (See Appendix B for a copy of this form).

The SCA is then notified of the release of the authorization by the data contractor and can bill the Medicaid FI for these expenses. If the SCA did not pay for the device/items, the SCA shall reimburse the actual purchaser within 10 calendar days of receipt of reimbursement.

The OAAS RO, or its designee, shall maintain documentation, including each beneficiary's assistive technology services form with original receipts and copies of cancelled checks, as record of payment to the purchaser. This documentation is for accounting and monitoring purposes.

Billing for assistive technology services must be completed within 60 calendar days after the set-up visit in order for the reimbursement to be paid.

Financial Management Services

Providers of Financial Management Services (FMS) are reimbursed at an established monthly rate. (See Appendix C – Billing Codes). The data contractor issues a monthly authorization to the Fiscal/Employer Agent (F/EA). The FEA uses the data contractor's database to retrieve PAs, but does not utilize the database to document the provision of services. The FEA may bill, using the proper PA, after services are delivered.

Span Date Billing

Specific services may be billed as span-dated. Each line on the claim form must represent billing for a single date of service for those services that cannot be span-dated. The following table identifies which services can or cannot be span-dated:

Services that CANNOT be Span-Dated	Services that CAN be Span-Dated
1. EAA 2. CTSS 3. PERS – Installation 4. ADMS -Telecare Installation, Assistive Device/Equipment Repair, Purchase and Rental, and ADMS Procurement 5. Nursing 6. SMT 7. Housing Transition or Crisis Intervention Services 8. Housing Stabilization Services 9. ADHC 10. PAS 11. Assistive Technology	1. HDMs 2. HDMs (including MTMs & Nutritional Counseling) 3. PERS 4. Monthly Service 5. ADMS -Telecare Monthly Service 6. MIHC Services 7. Support Coordination 8. FMS

Details about when claims can be filed for individual CCW services can be found in Section 7.5 – Service Access and Authorization of this manual.

PROGRAM OVERSIGHT AND REVIEW

Services offered through the Community Choices Waiver (CCW) are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal rules and regulations. Oversight is conducted through licensure compliance and program monitoring. The Louisiana Department of Health (LDH) Health Standards Section (HSS) staff conducts on-site reviews to assure state licensure compliance for the providers for which they license. The Office of Aging and Adult Services (OAAS) staff conducts reviews to monitor support coordination agencies' (SCAs') compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by beneficiaries served.

The OAAS Regional Office (RO) staff conduct on-site reviews of SCAs. Details about the SCA monitoring process are provided to support coordination providers at the time of enrollment. (Refer to Appendix B for the link to the SCA Monitoring Policy and Procedures Manual).

In addition to the OAAS formal monitoring process, OAAS will monitor compliance of the SCAs' duties, functions and requirements. If SCAs fail to comply with their requirements, they may be sanctioned accordingly as outlined in the OAAS SCA Performance Agreement document. (See Appendix C for the link to this document).

Health Standards Section Reviews

HSS reviews include an examination of administrative records, personnel records, and a sample of beneficiary records. In addition, providers are monitored with respect to the following:

1. Beneficiary access to needed services identified in the plan of care (POC) and individualized service plan (ISP), if applicable;

2. Quality of assessment and service planning;

3. Appropriateness of services provided including content, intensity, frequency, and beneficiary input and satisfaction; and

4. Internal quality improvement.

A provider's failure to follow State licensing standards could result in the provider's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

On-Site Reviews

HSS on-site review with a provider is unannounced to ensure licensure compliance. The on-site review is comprised of the following:

1. Administrative review;
2. Personnel record review;
3. Interviews; and
4. Beneficiary record reviews.

Administrative Review

The administrative review includes the following:

1. Review of administrative record;
2. Review of other agency documentation; and
3. Provider staff interviews as well as interviews with beneficiaries sampled 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 or liquidated damages and/or recoupment of payment.

Personnel Record Review

The personnel record review includes the following:

1. Review of personnel files;
2. Review of time sheets;
3. Review of the current organizational chart; and
4. Provider agency staff interviews to ensure that direct service providers (DSPs), and all supervisors meet the following staff qualifications:
    a. Education;

b. Experience;

c. Skills;

d. Knowledge;

e. Employment status;

f. Hours worked;

g. Staff coverage;

h. Supervision documentation; and

i. Other applicable requirements.

Interviews

As part of the on-site review, the HSS staff will interview the following:

1. A representative sample of the beneficiaries served by each provider employee;

2. Members of the beneficiary's network of support, which may include family and friends;

3. Direct care staff; and

4. Other members of the beneficiary's community. This may include support coordinators, support coordination supervisors, other employees of the SCA, DSPs, other employees of the DSP, and other employees of the Adult Day Health Care (ADHC) center, if applicable.

This interview process is to assess the overall satisfaction of beneficiaries regarding the provider's performance, and to determine the presence of the personal outcomes defined and prioritized by the beneficiary/legal representative.

Beneficiary Record Review

Following the interviews, HSS staff may review the case records of a representative sample of beneficiaries served. The records will be reviewed to ensure that the activities of the provider are associated with the appropriate services of intake, ongoing assessment, care planning, and transition/closure.

Recorded documentation is reviewed to ensure that the services reimbursed were, as follows:

1. Identified in the POC and ISP (if applicable);
2. Provided to the beneficiary;
3. Documented properly; and
4. Are appropriate in terms of frequency and intensity.

HSS staff will review the intake documentation of the CCW beneficiary's eligibility and procedural safeguards, support coordination and professional assessments/reassessment documentation, service plans, service logs, progress notes, and other pertinent information in the beneficiary record.

Report of Review Findings

Upon completion of the on-site review, HSS staff discusses the preliminary findings of the review in an exit interview with the appropriate provider staff. HSS staff compiles and analyzes all data collected in the review, and a written report summarizing their review findings and recommended corrective action is sent to the provider.

The review report includes the following:

1. Identifying information;
2. A statement of compliance with all applicable regulations; or
3. Deficiencies requiring corrective action by the provider.

HSS program managers will review the report and assess any sanctions as appropriate.

Corrective Action Report

The provider is required to submit a plan of correction to HSS within **10 working days of receipt of the report**.

The plan must address **how each cited deficiency has been corrected and how recurrences will be prevented**. The provider is afforded an opportunity to discuss or challenge the HSS monitoring findings.

Upon receipt of the written plan of correction, HSS program managers review the provider's plan to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the HSS program manager responds to the provider requesting immediate resolution of those deficiencies in question.

A follow-up review will be conducted when deficiencies have been found to ensure that the provider has fully implemented the plan of correction. Follow-up reviews may be conducted on-site or via evidence review.

Informal Dispute Resolution (Optional)

In the course of the review process, providers may request an informal hearing with HSS staff. The provider is notified of the right to an informal hearing in the correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits the provider's right to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix A for contact information.)

This request must be made within the time limit given for the corrective action recommended by HSS.

The provider is notified of time and place where the informal hearing will be held. 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 will conduct the hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the monitoring findings. The provider representatives are advised of the date that a written response will be sent and are reminded of the right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the Division of Administrative Law (DAL). (See Appendix A for contact information).

Fraud and Abuse

When HSS staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Program Integrity Section for investigation and sanctions, if necessary. Investigations, recoupments and sanctions may also be initiated from reviews conducted by the Surveillance and Utilization Review System (SURS) and/or Program Integrity Section. LDH has an agreement with the Attorney General's Office which provides for the Attorney General's office to investigate Medicaid fraud. The Office of the Inspector General (OIG), Federal Bureau of Investigation (FBI), and the Centers for Medicare and Medicaid Services (CMS) also conduct investigations of Medicaid fraud.

Support Coordination Agency Monitoring

The OAAS RO staff conducts annual monitoring of each SCA as a means of monitoring compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by beneficiaries served. The results of the monitoring process are reported to the SCA along with any required follow-up actions and timelines. Recurrent problems are to be addressed by the SCAs through systemic changes resulting in improvements. SCAs who do not perform all of the required follow-up actions according to the specified timelines are subject to sanctions.

SCAs are responsible for the following in the monitoring process:

1. Offering full cooperation with OAAS;
2. Providing policy and procedure manuals, personnel records, case records, and other documentation, as requested;
3. Providing space for documentation review and support coordinator interviews;
4. Coordinating with agency support coordinator interviews; and
5. Assisting with scheduling beneficiary interviews.

SCAs may refer to Appendix B for further information regarding the SCA monitoring process.

INCIDENTS, ACCIDENTS AND COMPLAINTS

Support coordination agencies (SCAs), Adult Day Health Care (ADHC) providers, and direct service providers (DSPs) are responsible for reasonably ensuring the health and welfare of the beneficiary and are required to report all incidents, accidents, or suspected cases of abuse, neglect, exploitation, or extortion. Reporting shall be in accordance with applicable laws, rules, and policies and be made to the appropriate agency named below. Only reporting to a supervisor does not satisfy the legal requirement to report. The supervisor shall be responsible for ensuring that reports or referrals are made in a timely manner to the appropriate agency.

For ADHC providers, refer to Medicaid ADHC Manual Chapter 9, Section 9.9-Incidents/Accidents/Complaints for details on reporting.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of all incidents and accidents involving the beneficiary. A report of the incident/accident shall be maintained in the beneficiary's record as well as the central records system. The report shall include:

1. Beneficiary identifying information;
2. Event information (including date, time, location, etc.) of the incident/accident;
3. Circumstances surrounding the incident/accident;
4. Description of the incident/accident (including any medical attention or law enforcement involvement, witnesses, etc.);
5. Action taken to correct or prevent future occurrence of incident/accident; and
6. Name of person completing the report.

Critical Incident Reports

Additional provider responsibilities apply to incidents defined as critical. Critical incidents include, but are not limited to, those involving:

1. Abuse;
2. Neglect;

3. Exploitation;
4. Extortion;
5. Major injury;
6. Major medical events;
7. Death;
8. Major behavioral incidents;
9. Involvement with law enforcement;
10. Loss or destruction of a beneficiary's home;
11. Falls; and
12. Major medication incidents.

Critical incidents are fully defined in the Office of Aging and Adult Services' (OAAS) *Critical Incident Reporting Manual* and includes the specific provider and SCA responsibilities that must be followed. Non-compliance will result in administrative actions. (See Appendix B for link to this manual).

Imminent Danger and Serious Harm

Providers must report all suspected cases of abuse (physical, mental, emotional, and/or sexual), neglect, exploitation, or extortion to the appropriate authorities. In addition, any other circumstances that place the beneficiary's health and well-being at risk should be reported to the appropriate authorities. (See Appendix A for contact information).

For beneficiaries ages 18 through 59 and emancipated minors, Adult Protective Services (APS) must be contacted. APS investigates and arranges for services to protect adults with disabilities at risk of abuse, neglect, exploitation, or extortion. (See Appendix A for contact information).

For beneficiaries aged 60 years or older, Elderly Protective Services (EPS) must be contacted. EPS investigates situations of abuse, neglect, and/or exploitation of individuals aged 60 years or older. (See Appendix A for contact information).

If the beneficiary needs emergency assistance, the worker must call 911 or the local law enforcement agency before contacting the supervisor.

The responsibilities of the SCA and providers (DSPs and ADHC providers) are outlined in the *OAAS Critical Incident Reporting Manual.* (See Appendix B for the link to this manual).

Internal Complaint Policy

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

1. 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 the following:

    a. Date the complaint was made;

    b. The name and telephone number of the complainant;

    c. Nature of the complaint; and

    d. Resolution of the complaint.

2. All written complaints must be forwarded to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator;

3. The complaint coordinator must send a letter to the complainant acknowledging receipt of the complaint **within five 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 responsible representative, the employee, and other interested parties. The agency/provider is encouraged to use all available resources to resolve the complaint internally. The employee's supervisor must be informed of the complaint and the resolution;

5. The agency/provider must inform the beneficiary, the complainant, and/or the responsible representative in writing **within 10 working days** of receipt of the complaint and the results of the internal investigation;

6. If the beneficiary is dissatisfied with the results of the provider's internal investigation, they may continue the complaint resolution process by contacting the Health Standards Section (HSS). (See Appendix A for contact information); and

7. If the beneficiary is dissatisfied with the results of the SCA's internal investigation, they may continue the complaint resolution process by contacting the OAAS Regional Office (RO). (See Appendix A for contact information).

ORGANIZED HEALTH CARE DELIVERY SYSTEM

An organized health care delivery system (OHCDS) is an entity with an identifiable component within its mission to provide services to individuals receiving Community Choices Waiver (CCW) services. The entity must be a qualified and enrolled Medicaid provider and must directly render at least one service offered in the CCW. As long as the entity furnishes at least one waiver service itself, it may contract with other qualified providers to furnish the other required waiver service.

Entities that function as an OHCDS must ensure that subcontracted entities meet all of the applicable provider qualification standards for the services they are rendering.

The OHCDS must attest that all provider qualifications are met in accordance with all of the applicable waiver provider qualifications as set forth in this manual chapter.

Prior to enrollment, an OHCDS must show the ability to provide all of the services available in the CCW on December 1, 2012 (see section 7.6 – Provider Requirements for a list of those particular services), with the exceptions of the following:

1. Support coordination;

2. Transition intensive support coordination (TISC);

3. Transition services; and

4. Adult day Health Care (ADHC) if there is no licensed ADHC provider in the service area.

CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Office of Aging and Adult Services (OAAS) State Office	Provides waiver assistance, clarification of waiver services, receives complaints regarding waiver services	OAAS P. O. Box 2031, Bin #14 Baton Rouge, LA 70821-2031 1-866-758-5035
OAAS Regional Office (RO)	Reviews and provides approval of waiver services, monitors support coordination services and offers providers technical assistance	http://ldh.la.gov/index.cfm/directory/category/141
Gainwell Technologies Provider Enrollment Unit	Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer	Gainwell Technologies Provider Enrollment Unit P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm
Gainwell Technologies Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information and billing issues	Gainwell Technologies Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Support/provider_supportindex.htm
Statistical Resources, Inc.	Agency to contact regarding LaSRS, electronic visit verification (EVV), and prior authorization (PA) billing issues	11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501
Division of Administrative Law (DAL) – Louisiana Department of Health (LDH) Section	Office to contact to request an appeal hearing	Division of Administrative Law 1020 Florida Street Post Office Box 44033 Baton Rouge, LA 70802 Phone: (225) 342-1800 Fax: (225) 342-1813 http://www.adminlaw.state.la.us

LDH Health Standards Section (HSS)	Office to contact to report changes that affect provider license (e.g. Address Change, Change of Ownership, etc.) Office to contact when providers wish to request an informal hearing as the result of provider's receipt of a statement of deficient practice or file a complaint against a provider by a beneficiary. a monitoring corrective action report or file a complaint against a provider agency	HSS P.O. Box 3767 Baton Rouge, LA 70821 1-800-660-0488
Medicaid Program Integrity	Office to contact to report Medicaid fraud	Provider Fraud Hotline# 1-800-488-2917 Beneficiary Fraud Hotline# 1-888-342-6207 Provider Fraud Fax: (225) 216-6129 Beneficiary Fraud Fax: (225) 389-2610 http://ldh.la.gov/index.cfm/page/219
Adult Protective Services (APS)	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors	1-800-898-4910
Elderly Protective Services (EPS)	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older	1-833-577-6532
Myers and Stauffer LC	Information about filing cost reports	https://myersandstauffer.com/client-portal/louisiana/
Adult Day Health Care (ADHC) Resources	Resources containing provider training and/or cost report training	http://ldh.la.gov/index.cfm/newsroom/detail/1573

Healthy Louisiana (Medicaid Managed Care Organizations (MCOs))	Healthy Louisiana (previously called Bayou Health) is the way most of Louisiana's Medicaid and LaCHIP beneficiaries receive health care services. In Healthy Louisiana, Medicaid beneficiaries enroll in a Health Plan	http://ldh.la.gov/index.cfm/subhome/6
LDH – Medicaid Rate Setting and Audit Section	Agency to call about provider rate methodologies, cost reports, audits, and cost settlements	https://ldh.la.gov/page/rate-audithomepage 225-342-6116

FORMS/DOCUMENTS/LINKS

The following documents, forms, links, and manuals are available on the following website addresses:

Form/Document/Website Name	Website Address
Back-Up Staffing Plan	http://ldh.la.gov/assets/docs/OAAS/EmergencyPrep/BackupStaffingPlanForm.pdf
Emergency Plan	http://www.ldh.la.gov/assets/docs/OAAS/EmergencyPrep/EmergencyPlanandAgreementForm.pdf
Rights and Responsibilities for Applicants/Participants of Home and Community-Based Services (HCBS) Waiver	http://www.ldh.la.gov/assets/docs/OAAS/publications/RightsRespon_Waivers.pdf
Community Choices Waiver (CCW) Service Log	http://www.ldh.la.gov/assets/docs/OAAS/publications/ServiceLogs/CCWServiceLogAndInstructions.pdf
Electronic Visit Verification (EVV)	http://ldh.la.gov/index.cfm/page/2751
Transition Services Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Transition-Services-Form.pdf
Assistive Devices and Medical Supplies (ADMS) Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Assistive-Devices-and-Medical-Supplies-Form.pdf
Environmental Accessibility Adaptation (EAA) Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Environmental-Accessibility-Adaptation-Form.pdf
Nursing/Therapy Payment Authorization Form	https://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Nursing-Therapy-Payment-Authorization-Form.pdf
Monitored In-Home Caregiving (MIHC) Services Form	https://www.ldh.la.gov/assets/docs/OAAS/publications/Forms/Monitored-In-Home-Caregiving-Services-Form.pdf

Form/Document/Website Name	Website Address
Office of Aging and Adult Services (OAAS) Critical Incident Reporting webpage	http://www.ldh.la.gov/index.cfm/newsroom/detail/1418?uuid=1295548571800
OAAS Critical Incident Reporting Manual	https://ldh.la.gov/assets/docs/OAAS/CIR/Critical-Incident-Reporting-Manual.pdf
Louisiana Department of Health (LDH) OAAS CCW Self-Direction Employer Handbook	http://www.ldh.la.gov/assets/docs/OAAS/Manuals/Self-Direction-Manual.pdf
LDH OAAS Permanent Supportive Housing (PSH) Policies and Procedure Manual	http://www.ldh.la.gov/assets/docs/OAAS/PSH/PSHManual.pdf
CCW PSH Housing Stabilization Services Housing Transition/Crisis Intervention Services Progress Note Form	http://www.ldh.la.gov/assets/docs/OAAS/publications/PSHProgressNote.pdf
Request for Payment/Override Form	http://www.ldh.la.gov/assets/docs/OAAS/publications/Forms/Request-for-Payment-Override-Form.pdf
National Voter Registration Act (NVRA) Resources	https://ldh.la.gov/news/category/142
Support Coordination Contact Documentation	https://ldh.la.gov/assets/docs/OAAS/CCWForms/Support-Coordination-Documentation-Form-Fillable.pdf
OAAS CCW PAS: Direct Service Worker (DSW)/Participant Relationship and Living Arrangements Guidance	https://ldh.la.gov/assets/docs/OAAS/CCWForms/OAAS-PC-16-001-CCW-PAS-DSW-Participant-Relationship-and-Living-Arrangements-Guidance-I-6-25-24.pdf

Form/Document/Website Name	Website Address
OAAS Telehealth/Virtual Contact Policy	https://ldh.la.gov/assets/docs/OAAS/Support-Coordination-Documents/OAAS-TELEHEALTH-POLICY-I-9-13-23.pdf
Support Coordination Agency (SCA) Monitoring Policy and Procedures Manual	http://www.ldh.la.gov/assets/docs/OAAS/Manuals/Support-Coordination-Monitoring-Policy-Procedures.pdf
OAAS SCA Performance Agreement	https://ldh.la.gov/assets/docs/OAAS/Support-Coordination-Documents/OAAS-SC-12-009-SCA-Performance-Agreement-RI-4-21-23-WATERMARK.pdf
OAAS Waiver Procedures Manual (for Regional Offices and SCAs)	http://www.ldh.la.gov/index.cfm/newsroom/detail/2923
Support Coordination Transfer of Records Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Support-Coordination-Transfer-of-Records-Form.pdf
Louisiana State Adverse Actions List Search Database	https://adverseactions.ldh.la.gov/SelSearch
Federal System Award Management	https://www.sam.gov/SAM/
Medicaid Services Chart	http://www.ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf
Medically Tailored Meals (MTMs)/Nutritional Counseling Referral Form	https://ldh.la.gov/assets/docs/OAAS/CCWForms/MTMs-NC-Referral-Form.pdf
OAAS Reference Documents for HCBS Programs	https://ldh.la.gov/assets/docs/OAAS/Support-Coordination-Documents/OAAS-ADM-24-004-OAAS-Reference-Document-for-HCBS-Programs-I-3-20-24.pdf

Form/Document/Website Name	Website Address
Assistive Technology Form	https://ldh.la.gov/assets/docs/OAAS/CCWForms/Assistive-Technology-Form.pdf
Adult Day Health Care (ADHC) Resources	http://ldh.la.gov/index.cfm/newsroom/detail/1573
Chapter 1 General Information and Administration Manual (Fee-for-Service)	https://www.lamedicaid.com/provweb1/providermanuals/manuals/GIA/GIA.pdf
ADHC Waiver Rule – Louisiana Administrative Code (LAC) Title 50: Part XXI. Subpart 3. ADHC	https://www.doa.la.gov/media/vs3btetk/50.pdf
ADHC Providers Reimbursement Methodology and Cost Reporting Rule – LAC Title 50: Part XXI. Chapter 7. Subchapter B	https://www.doa.la.gov/media/vs3btetk/50.pdf
ADHC Licensing Rule– LAC Title 48: Part I. Subpart 3. Chapter 42. Adult Day Health Care	https://www.doa.la.gov/media/15odwaqn/48v01.pdf
HCBS Providers Licensing Rule – LAC Title 48: Part I. Subpart 3. Chapter 50. HCBS Providers Licensing Standards	https://www.doa.la.gov/media/15odwaqn/48v01.pdf
HCBS Waivers General Provisions Rule – LAC Title 50: Part XXI. HCBS Waivers; Subpart 1. Chapters 1 -3.	https://www.doa.la.gov/media/vs3btetk/50.pdf
HCBS Waivers Provider Requirements Rule – LAC Title 50: Part XXI. HCBS Waivers; Subpart 1. Chapter 9.	https://www.doa.la.gov/media/vs3btetk/50.pdf
Support Coordination Standards for Participation for OAAS Waiver Programs Rule – LAC Title 50: Part XXI. Subpart 1. Chapter 5. Subpart 9. Personal Care Services (PCS) Chapter 129. Long-Term Care (LTC)	https://www.doa.la.gov/media/vs3btetk/50.pdf

Form/Document/Website Name	Website Address
Criminal History Background Checks on Non-Licensed Persons & Criminal Conviction Listing Preventing Employment – Louisiana Revised Statute (La. RS) 40:1203.1 et seq.	https://legis.la.gov/Legis/Law.aspx?p=y&d=964762
Code of Federal Regulations (CFR) - Minimum Protection Requirements – Not Hiring Convicted Criminals – 42 CFR 441.404(b)	https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-I/section-441.404
CCW – LAC Title 50: Part XXI. Subpart 7. CCW	https://www.doa.la.gov/media/vs3btetk/50.pdf
MIHC – LAC Title 48: Part I. Subpart 3. Chapter 51. MIHC	https://www.doa.la.gov/media/15odwaqn/48v01.pdf
HCBS Waivers – LAC Title 50: Part XXI. Subpart 1. General Provisions; Chapters 1 & 3.	https://www.doa.la.gov/media/vs3btetk/50.pdf

BILLING CODES/FEE SCHEDULE

Information on procedure codes and the current rates are available at on the Office of Aging and Adult Services (OAAS) Community Choices Waiver (CCW) Services Procedure Codes/Rates (Fee Schedule) document at:

https://www.lamedicaid.com/provweb1/fee_schedules/CommChoWaiverBillingCodesRate_Current.pdf

CLAIMS RELATED INFORMATION

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 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

NOTE: Electronic claims submission is the preferred method for billing. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

This appendix includes the following:

1. Instructions for completing a CMS-1500 claim form and samples of completed CMS-1500 claim forms; and

2. Instructions for adjusting/voiding a claim and samples of adjusted CMS-1500 claim forms.

CMS-1500 (02/12) Instructions for Waiver Services

In order to access the CMS-1500 (02/12) Instructions for Waiver Services and to view sample forms, use the following link: https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500.htm.

NOTE: You must write "WAIVER" at the top center of the claim form.

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice (RA), a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; and

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 Remittance Advice

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.

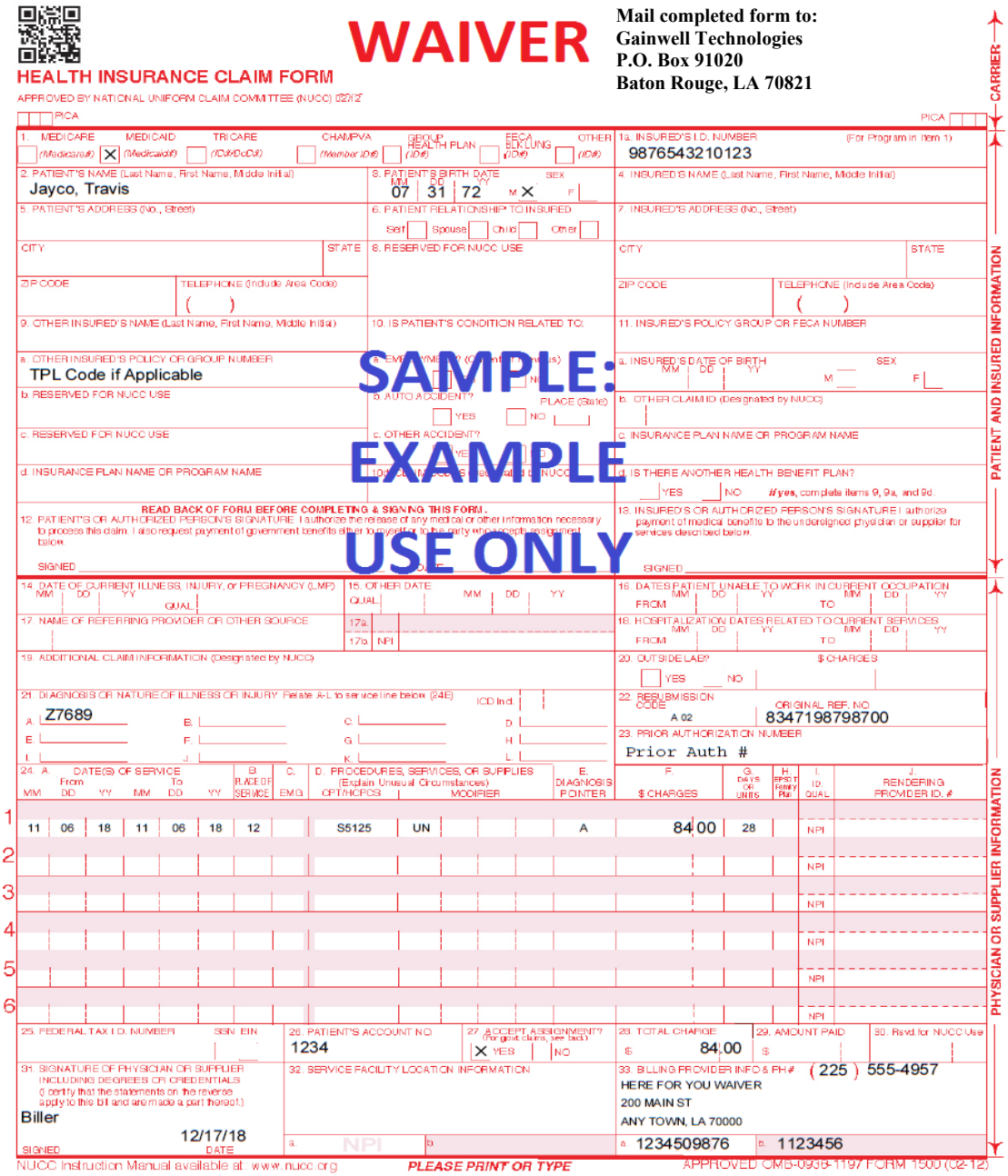
When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the RA.

Providers should refer to the General Information and Administration Provider Manual chapter of the Medicaid Services Manual located on the Louisiana Medicaid website for general information concerning topics relative to general claims filing. In order to access the General Information and Administration Provider Manual Chapter, click here: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf.

Sample forms are on the following pages.

SAMPLE WAIVER CLAIM FORM ADJUSTMENT



WAIVER

HEALTH INSURANCE CLAIM FORM

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

Mail completed form to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

PICA

1. MEDICARE (Medicare#) | MEDICAID (X) (Medicaid#) | 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): 9876543210123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jayco, Travis

3. PATIENT'S BIRTH DATE: 07 31 72 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

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:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if Applicable

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, complete items 9, 9a, and 9d.

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 QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.

A Z7689 B C D

E F G H

I J K L

22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO.: 8347198798700

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 (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	11	06	18	11	06	18	12		S5125	UN		A	84 00	28		NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 84.00

29. AMOUNT PAID $

30. Rsvd. 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.)

Biller

SIGNED 12/17/18 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (225) 555-4957

HERE FOR YOU WAIVER
200 MAIN ST
ANY TOWN, LA 70000

a. 1234509876 b. 1123456

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

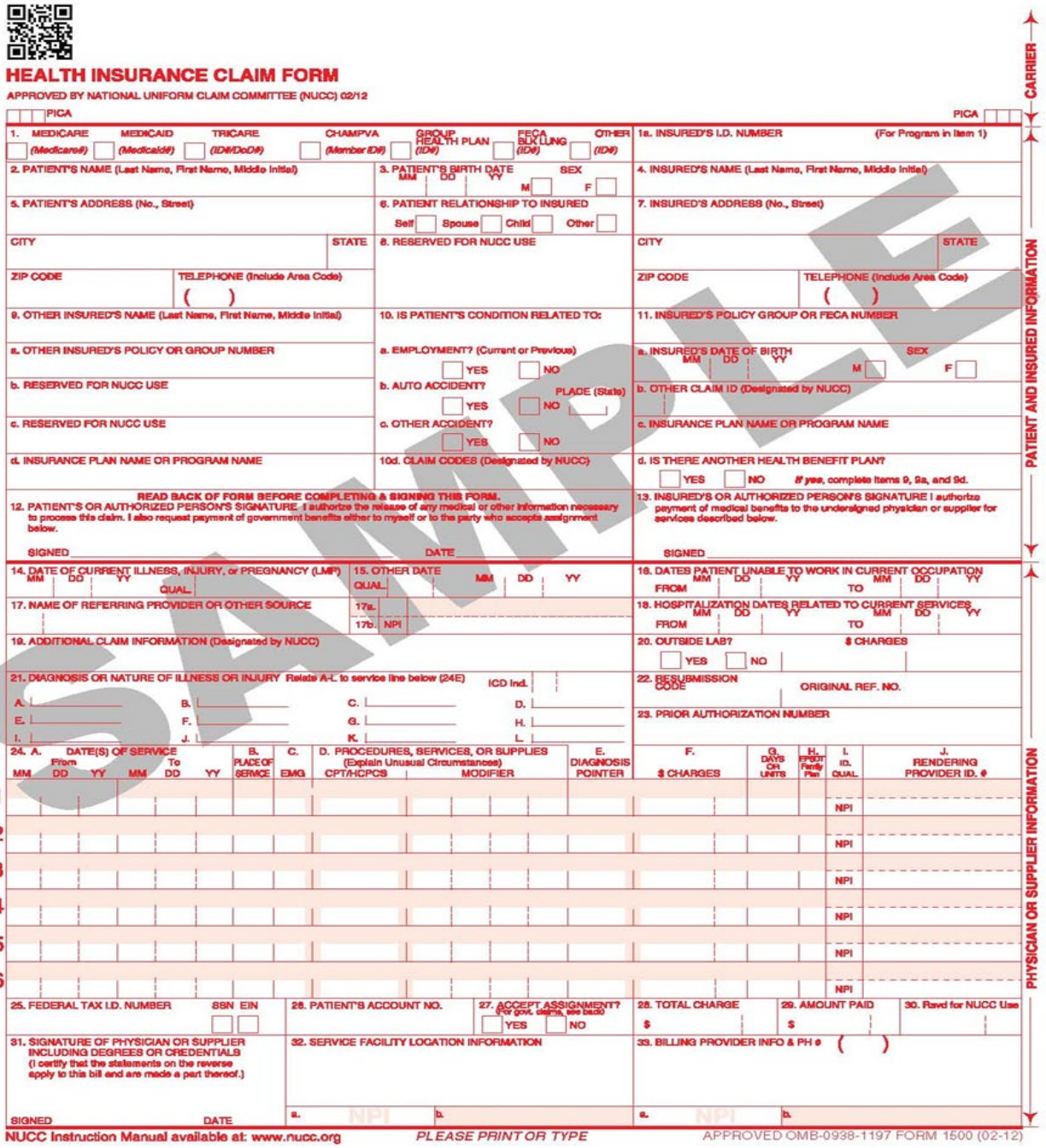
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE: EXAMPLE USE ONLY

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) 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)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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 QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Community Choices Waiver (CCW) Manual Chapter.

Abuse – The infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical 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. (Louisiana Revised Statute (La. RS) 15:1503)

Abuse of Medicaid Funds – Inappropriate use of public funds by either providers or beneficiaries, including practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

Activities of Daily Living (ADL) – The functions or basic self-care tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. ADL include bathing, dressing, eating, grooming, walking, transferring and/or toileting. The extent to which a person requires assistance to perform one or more of these activities often is a level of care (LOC) criterion.

Adult Day Health Care (ADHC) – A medical model ADHC program designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community-based direct care center.

ADHC Center – Any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more adults with functional impairments who are not related to the owner or operator of such agency are provided with ADHC services. This center type will be open and providing services at least five continuous hours in a 24-hour day for at least five days per week.

ADHC Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 22-64 and have a physical disability, and meet nursing facility level of care (NFLOC) requirements.

ADHC Waiver Request for Services Registry (RFSR) – A waiting list for the ADHC Waiver program which contains the names and dates of requests of individuals applying for an ADHC Waiver opportunity.

Advocacy – The process of assuring that beneficiaries receive appropriate high quality supports and services and locating additional services needed by beneficiaries which are not readily available in the community.

Agency – An entity which delivers Medicaid support coordination services under an agreement with the Louisiana Department of Health (LDH)/Office of Aging and Adult Services (OAAS).

Allegation of Non-Compliance – A claim that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a beneficiary or beneficiaries. (La. RS 40:2009.14)

Allowable Cost – Those expenses incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied during the desk review and audit process to determine allowable costs.

Appeal – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination; a legal proceeding in which the applicant/enrollee and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer (See "Fair Hearing").

Applicant – An individual who is requesting Medicaid Waiver services.

Assessment – One or more processes that are used to obtain information about a person, including their condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person meets NFLOC and requires waiver services. The results are used to develop the plan of care (POC) and an individualized service plan (ISP).

Beneficiary - An individual who has been certified for the CCW program. A beneficiary may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) – The Bureau within LDH is responsible for the administration of the Medicaid Program and is the administering agency for the OAAS Waiver programs.

Case Management – (See "Support Coordination").

Centers for Medicare and Medicaid (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

Community Choices Waiver (CCW) – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 21-64 and have a physical disability, and meet the NFLOC requirements.

CCW RFSR – A waiting list for the CCW program which contains the names and dates of requests of individuals applying for a CCW opportunity.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a beneficiary or beneficiaries (La. RS 40:2009.14).

Continuous Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to pursue opportunities to improve services, and to correct identified problems.

Confidentiality – The process of protecting a beneficiary's or an employee's personal information, as required by the Health Insurance Portability and Accountability Act (HIPAA).

Corrective Action Plan – Written description of action a provider plans to take to correct identified deficiencies.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Direct Care Staff – Unlicensed staff paid to provide personal care and other direct service and support to persons qualified waiver beneficiaries to enhance their well-being, and who are involved in face-to-face direct contact with the participant.

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to beneficiaries. The EVV system will ensure that beneficiaries are receiving services authorized in their POCs, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Eligibility – The determination of whether or not a beneficiary qualifies to receive services based on meeting established criteria as set by LDH.

Enrollment – A determination made by LDH that a provider or agency meets the necessary requirements to participate as a Medicaid provider. This is also referred to as provider enrollment.

Exploitation – The illegal or improper use or management of the funds, assets or property, of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage. (La. RS 15:1503)

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. RS 15:1503)

Fair Hearing – A legal proceeding in which the beneficiary and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer.

Fiscal Intermediary (FI) – The contractor, managed by Medicaid, which processes claims, issues payments to providers and agencies, handles provider inquiries and complaints, provides training for providers.

Follow-Up – A core element of service delivery to the beneficiary that includes oversight and monitoring of the provision of services, ongoing assessment and mitigation of health, behavioral and personal safety risk, and crisis management.

Formal Services – Another term for professional and paid services.

Freedom of Choice (FOC) – A term used when the applicant/beneficiary is selecting the provider(s) and support coordination agency (SCA) that will provide their services.

Good Cause – An acceptable reason to change agencies or providers outside of the designated circumstances and timelines.

Health Standards Section (HSS) – A section of LDH responsible for the licensure and enforcement of compliance of those health care providers licensed by HSS.

Home and Community-Based Services (HCBS) Waiver – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the beneficiary's home or community as an alternative to institutional services to persons who meet NFLOC. Waiver services are approved by CMS are limited to serving a specific number of individuals in accordance with the approved and available waiver opportunities.

Individualized Service Plan (ISP) – An individualized written plan of action to be completed and followed by providers to address the beneficiary's difficulties, health care needs, and services based upon their assessment. A comprehensive POC prepared in accordance with policies, procedures, and timelines established by Medicaid or by an LDH program office for reimbursement purposes may be substituted or used for the individual service plan for in-home

providers.

Informal Services – Another term for non-professional and non-paid services provided by family, friends and community/social network.

Institutionalization – The placement of an individual in an inpatient facility including, but not limited to a hospital, nursing facility, or psychiatric hospital.

Internal Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to pursue opportunities to improve services, and to correct identified problems.

Licensed Practical Nurse (LPN) – An individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana. The LPN works under the supervision of a registered nurse (RN).

Licensure – A determination by the HSS that a provider meets the requirements of State law to provide health care and services.

Linkage – Act of connecting a beneficiary to a specific SCA or service provider.

Long-Term – Personal Care Services (LT-PCS) – A Medicaid state plan service which provides assistance with ADL and instrumental activities of daily living (IADL) as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older and meet specific program requirements.

Louisiana Department of Health (LDH) - The state agency responsible for administering the state's Medicaid Program and other health-related services including aging and adult services, public health, mental health, developmental disabilities, and behavioral health services.

Louisiana Service Reporting System (LaSRS) – A secure modular web application developed by an LDH contractor to issue prior authorizations (PAs) and confirm post authorizations through EVV.

Medicaid – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by LDH or any other state agency. (LA RS 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the beneficiary's ADL. (La. RS 40:2009.14)

Neglect – The failure by a care giver 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 their well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused (La. RS 15:1503).

Non-Allowable Costs – Costs that are not based on the reasonable cost of services covered under Medicare/Medicaid and are not related to the care of beneficiaries.

Nursing Facility – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides intermediate, skilled nursing, and/or long-term care (LTC) for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within LDH that is responsible for the management and oversight of certain Medicaid HCBS waiver programs, state plan programs, adult protective services (APS) for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

OAAS Regional Office (RO) – One of nine administrative offices within OAAS.

Office of Behavioral Health (OBH) – The office in LDH responsible for services to individuals with behavioral or addictive disorders.

Office of Public Health (**OPH**) – The office in LDH responsible for personal and environmental health services.

Office for Citizens with Developmental Disabilities (OCDD) – The office in LDH responsible for services to individuals with developmental disabilities.

Personal Outcome – Result achieved by or for the waiver beneficiary through the provision of services and supports that make a meaningful difference in the quality of the individual's life.

Person-Centered – An approach used in the assessment and planning processes that considers a beneficiary's personal experiences and preferences.

Plan of Care (POC) – A written person-centered plan developed by the beneficiary, their authorized representative and support coordinator based on assessment results. The plan specifies services to be accessed and coordinated by the support coordinator on the beneficiary's behalf and includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Program of All-Inclusive Care for the Elderly (PACE) – Program which coordinates and provides all needed preventive, primary health, acute and long-term care services to qualified beneficiaries age 55 and older in order to enhance their quality of life and allow them to continue to live in the community.

Progress Notes – Documentation of the delivery of services, activities, and/or observations to record important information as applicable.

Provider – An entity that delivers Medicaid services under a provider agreement with LDH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other LDH office. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other LDH funding source.

Provider Enrollment – See "Enrollment".

Reassessment – See "Assessment". The re-assessment is completed at least annually for waiver beneficiaries and when a significant status change occurs in order to update the POC and/or ISP.

Registered Nurse (RN) – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible beneficiary.

Responsible Representative – An adult who has been designated by the beneficiary to act on their behalf with respect to their services. The written designation of a responsible representative does not give legal authority for that individual to independently handle the beneficiary's business

without the beneficiary's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Self-Neglect – The failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. RS 15:1503)

Service Logs - Documentation of the delivery of personal assistance services (PAS) and Caregiver Temporary Support Services (CTSS), activities and observations of a beneficiary.

Sexual Abuse – Any non-consensual sexual activity between a beneficiary and another individual. 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 the beneficiary is not capable of or competent to refuse.

Support Coordination – Services provided to eligible beneficiaries to help them gain access to the full range of needed services including medical, social, educational, housing, and other support services regardless of the funding source for these services. Activities also include assessment, POC development, service monitoring, critical incident management, and transition/discharge.

Support Coordinator – An individual who meets the required qualifications and who is employed by a SCA.

Transition – A shift from a beneficiary's current services to another appropriate level of services, including discharge from all services.

Waiver Opportunity – An offer made to an individual on the CCW RFSR. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.

CONCURRENT SERVICES

Waiver services that are available while a beneficiary is in a hospital or in a nursing facility are considered concurrent services. Some Community Choices Waiver (CCW) services are payable when a beneficiary is in a hospital or nursing facility. All services must be prior approved as indicated in Section 7.1 – Covered Services.

The following CCW services are payable when a beneficiary who has been receiving CCW services has a temporary stay in a hospital or a nursing facility or when a beneficiary is transitioning from a nursing facility to the community:

Payable Waiver Services During a Temporary Stay in a Nursing Facility or Hospital
1. Support Coordination; 2. Personal Emergency Response System (PERS) – Initial Installation; 3. PERS – Monthly Maintenance; 4. Environmental Accessibility Adaptation (EAA) – Ramp; 5. EAA – Lift; 6. EAA – Bathroom; 7. EAA – Other Adaptations; 8. EAA – Basic Assessment and Approval; 9. EAA – Complex Assessment and Approval; 10. Physical Therapy (PT) Assessment; 11. Occupational Therapy (OT) Evaluation; 12. Speech Language Hearing Evaluation; 13. Swallowing Function Evaluation; 14. Nursing Service Assessment; 15. Telecare Activity and Sensor Monitoring (ASM) – Equipment Installation; 16. Telecare ASM – Monitoring, Routine Maintenance and Rental; 17. Assistive Device/Equipment Purchase (not covered under Medicare or Medicaid State Plan); 18. Assistive Device/Equipment Rental including Routine Repair and Maintenance (not covered under Medicare or Medicaid State Plan); 19. Assistive Device Equipment Repair; 20. Telecare – Health Status Monitoring (HSM) – Monitoring, Routine Maintenance and Rental; 21. Telecare – Medication Dispensing and Monitoring; 22. Housing Stabilization Services; and 23. Housing Transition or Crisis Intervention Services.

Payable Waiver Services When Transitioning from a Nursing Facility to the Community
1. Transition Intensive Support Coordination (TISC); 2. Transition Services; 3. EAA – Ramp; 4. EAA – Lift; 5. EAA – Bathroom; 6. EAA – Other Adaptations; 7. EAA – Basic Assessment and Approval; 8. EAA – Complex Assessment and Approval; and 9. Housing Transition or Crisis Intervention Services.

DATABASE CHECKS

Providers must screen potential and active employees using the following databases:

1. **Louisiana State Adverse Actions List; and**

2. **Office of Inspector General (OIG) List of Excluded Individuals.**

Potential employees must be screened for any exclusions **AND** adverse actions **upon hire**.

All employees must be screened **MONTHLY** using the adverse actions database **AND** the exclusion database.

Providers **MUST** retain the database checks' print outs/documents as documentation that these checks were completed upon hire and monthly thereafter.

Louisiana State Adverse Actions List Search Database

The provider will:

1. Go to https://adverseactions.ldh.la.gov/selsearch; and

2. Check for potential employees/employees:

   a. Type in the potential employee/employee's social security number (SSN), name and/or any other names that the individual typically goes by (if applicable); and

   b. Click on the search button to bring up existing records.

Office of Inspector General List of Excluded Individuals Database

The provider will:

1. Go to https://exclusions.oig.hhs.gov/; and

2. Check for potential employees/employees:

a. Type in the potential employee/employee's name and/or any other names that the individual typically goes by (if applicable);

b. Click on the search button to bring up existing records;

c. If a record with the potential employee/employee's name is found, click verify; and

d. Enter the SSN to verify the match.

What to do with the results of these checks?
For both of the databases stated above, if no results are found, this individual is not currently excluded and may begin/continue employment with your agency. **Regardless of the database results, the provider MUST keep documentation as proof that these searches were conducted.** If the potential employee/employee's name appears on one of the databases listed above, you **CANNOT**: 1. Hire that individual as an employee; and/or 2. Allow the employee to continue working for your agency.