EPSDT – Targeted Population

SUPPORT COORDINATION TRAINING

Purpose of the Training

To establish a uniform training module for the Support Coordination agency's Designated Trainer and Supervisors to use in conjunction with the Support Coordination Training Handbook.

This Training Module will be used:

- For new support coordinators, supervisors and trainers hired to serve the EPSDT – Targeted Population as part of the 16 hours of orientation training.
- For existing EPSDT support coordinators, supervisors and trainers as part of the 20 hours of annual training.
- As reference material for support coordinators and supervisors.

Documents Required For Training

An electronic copy of the EPSDT – Targeted Population Support Coordination Training Handbook & Appendices has been given to each agency. The Appendices are mandatory forms that should help the Support Coordinator meet the needs of EPSDT beneficiaries.

The PowerPoint presentation will be e-mailed to each agency after completion of the training along with clarification of questions and answers.

The Handbook contains more detailed information than is provided in this presentation.

Current training materials can be found at:
https://ldh.la.gov/page/4981

EPSDT Training Module

Part 1 – Overview

Part 2 – Services Available to EPSDT Beneficiaries

Part 3 – Components of Support Coordination

Part 4 – Coordination of Services

Part 5 – EPSDT Support Coordination Requirements

Part 1

OVERVIEW

Louisiana Medicaid

The Medicaid program provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Currently in Louisiana, more than 2 million people are enrolled in Medicaid.

The Louisiana Medicaid Program is the “State Plan” and operates within the Louisiana Department of Health (LDH), according to federal laws and regulations.

Medicaid is the payer of last resort.

Medicaid provides medically necessary services.

EPSDT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventative health care services for children under age 21 who are enrolled in Medicaid.

EPSDT is key to ensuring that children and adolescents receive appropriate preventative, dental, behavioral health, and specialty services.

The goal of EPSDT is to ensure children in Medicaid have the opportunity to reach their full health potential – *the right care, to the right child, at the right time, in the right setting*.

EPSDT

Early: Assessing and identifying problems early

Periodic: Checking children's health at periodic, age-appropriate intervals

Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnostic: Performing diagnostic tests to follow up when a risk is identified, and

Treatment: Control, correct or reduce health problems found.

EPSDT-Targeted Population Support Coordination

Support Coordination is a service provided by Louisiana Medicaid through performance agreements with agencies to serve Medicaid beneficiaries in one of several Medicaid programs, such as EPSDT.

EPSDT Support Coordination was established as a result of a lawsuit, Chisholm vs. LDH, to provide support coordination to those individuals who have disabilities and/or chronic health conditions.

Support Coordinators:

- link individuals to services and assist them with gaining access to needed medical, social, educational and other services
- identify additional services that might help individuals, even before the family requests those services
- ease the process of receiving services by helping to manage the care of the child and limit gaps between service providers

Chisholm Class Members

Chisholm class members are:

- Beneficiaries under the age of 21 who are eligible for the Louisiana Medicaid Program, and
- who are listed on the Developmental Disabilities Request for Services Registry.

EPSDT-Targeted Population Support Coordination Eligibility

Individuals on the Developmental Disabilities Request for Services Registry (DD RFSR) or individuals for whom the service is determined medically necessary, with documentation to substantiate that they meet the definition of special needs *(Appendix P)*,

AND

Under the age of 21,

AND

Are Medicaid Eligible.

How to Access EPSDT Support Coordination

Beneficiaries may elect to receive or discontinue EPSDT Support Coordination at any time. Discontinuing EPSDT Support Coordination does not affect a beneficiary's eligibility to receive Medicaid services or their placement on the DD RFSR. **Beneficiaries may request to resume EPSDT Support Coordination Services at any time by calling SRI toll-free at 1-800-364-7828 and requesting Support Coordination for EPSDT**.

If an individual is not yet on the DD RFSR they can contact their Local Governing Entity. Refer to *Appendix J-1 – LGE Directory.*

If they receive a Statement of Denial from OCDD they may still be eligible for EPSDT SC if they meet the definition of Special Needs. Refer to *Appendix H – EPSDT Support Coordination Fact Sheet* for full definition.

Louisiana Medicaid

Fee-for-Service Medicaid (FFS)

- Traditional Medicaid for people who are not enrolled in a Managed Care Organization (MCO) for most of their health services.

Medicaid Managed Care (MCO)

- Managed care system for physical health, specialized behavioral health and non-emergency medical transportation services.
- Covers 1.82 Million Louisianans
- Healthy Louisiana is the way most of Louisiana's Medicaid beneficiaries receive health care services.

Medicaid Managed Care (MCO)

The Louisiana Department of Health (LDH) contracts with Managed Care Organizations (MCO) that deliver health care services through their provider networks. Some of these MCOs have a different network of doctors, hospitals, and other providers (physical, behavioral, pharmacy, and Ancillary Service providers) than traditional Medicaid.

All MCOs offer the same core medical, behavioral health and substance use treatment services. The plans also offer extra value-added Medicaid benefits and services that could differ.

Six managed care organizations (MCOs) working statewide:

- Aetna Better Health
- AmeriHealth Caritas
- Healthy Blue
- Humana Healthy Horizons
- Louisiana Healthcare Connections
- UnitedHealthcare Community Plan

Medicaid Eligibility and Enrollment Types

Determining eligibility for Medicaid is the responsibility of the Bureau of Health Services Financing (BHSF).

The Louisiana Medicaid managed care program is comprised of mandatory and voluntary opt-in populations. LDH is responsible for determining eligibility for enrollment in the MCO. We broadly refer to enrollees with P-linkages or B-linkages.

> **P-linkage:** Refers to enrollment in an MCO for physical health, specialized behavioral health services (SBHS), and transportation services.
>
> **B-linkage:** Refers to enrollment in an MCO for specialized behavioral health services (SBHS) and transportation services, and Fee-for-Service Medicaid for physical health services.

Some of the **mandatory** and **voluntary opt-in** populations are discussed on the following slides. For more information on Medicaid eligibility and enrollment contact Medicaid hotline toll free at 1.888.342.6207. Agents are accepting calls Monday through Friday from 8 a.m. to 4:30 p.m.

Chisholm Class Members – Voluntary Opt-In

Chisholm Class Members – Beneficiaries under the age of 21 who are eligible for the Louisiana Medicaid Program, and who are listed on the Developmental Disabilities Request for Services Registry, are Chisholm Class Members.

Chisholm Class Members are part of the **voluntary opt-in population** meaning they may choose to have all of their health care through the MCO or only their specialized behavioral health and transportation services through the MCO. This is called "opt-in."

P-Linkage if Opt-In: will receive all Medicaid covered services through their MCO including physical health, specialized behavioral health and transportation services.

B-Linkage if stay in Fee-for-Service Medicaid: will receive their physical health services through FFS and will receive specialized behavioral health and transportation services through their MCO.

Act 421 / TEFRA - Mandatory

Act 421 Children's Medicaid Option – The Act 421-CMO extends Medicaid eligibility to children covered by § 1902(e)(3) of the Social Security Act, i.e., children age 18 and younger who meet institutional level of care (Nursing Facility, Hospital, Intermediate Care Facility for Individuals with Intellectual/Developmental Disabilities) and are in families with income that is too high to qualify for Medicaid, who could otherwise become Medicaid eligible if receiving extended care in an institutional setting. With the exception of children with dual coverage in Medicare and Medicaid, **enrollment in managed care is required of all participants** in order to control costs and enhance budget predictability.

P-Linkage: will receive all Medicaid covered services through their MCO including physical health, specialized behavioral health and transportation services.

Coordinated System of Care - Mandatory

Coordinated System of Care (CSoC) Children - Children who are deemed clinically and functionally eligible and participate in the CSoC program receive all Medicaid covered specialized behavioral health (SBHS) services through the CSoC contractor, Magellan of Louisiana, except Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home, and Substance Use Disorder (SUD) Residential services which are covered by their MCO. The MCOs will implement procedures to coordinate services it provides to the enrollee with the services the Enrollee receives from the CSoC contractor including sharing the results of the any identification and assessment of that Enrollee's needs to prevent duplication of those activities.

CSoC children will receive the following services through their MCO:

- Physical health services and
- Transportation services.

Choosing an MCO

The Enrollment Broker can provide Choice Counseling which includes answering beneficiary's questions and providing information in an unbiased manner on available MCOs and advising Potential Enrollees and Enrollees on what factors to consider when choosing among them. Beneficiaries may contact the Enrollment Broker at 1-855-229-6848.

Things beneficiaries should consider before selecting an MCO

1. Access to their current doctors and other healthcare providers

Not all doctors and healthcare providers are enrolled in all the managed care plans. If you want to keep your doctors, it's important to confirm that they are all enrolled in the plan you choose.

Support Coordinators should assist Chisholm Class Members with determining if their current providers are in-network. You can search for providers by plan at: MyPlan.healthy.la.gov.

Things beneficiaries should consider before selecting an MCO

2. Access to prescription medications

It's important to check that you can access needed medications on the new plan.

Supports Coordinators should ensure that the medications that they are currently prescribed are covered by the MCO's formulary.

A common preferred drug list can be found at: https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

It is important to check any medications not listed on the common preferred drug list with each of the plans to see if it is covered. Each plan covers different drugs and has different prior authorization and step therapy procedures.

Refer to Handbook – Choosing a MCO section for links to each MCOs pharmacy benefits page.

Things beneficiaries should consider before selecting an MCO

3. Access to services

The MCO will be determining the services, amounts, and duration of services to be received. The MCO has to provide the same amount, duration, and scope as FFS.

MCOs offer **value added benefits** to their members which are currently non-covered services by the Louisiana Medicaid State Plan. A complete listing of each MCO's value added benefits can be found on the MCO Comparison Chart.

Examples of Value Added Benefits include:

- $25 reward for completing health needs assessment, flu shot, child wellness visits, vaccinations, etc.
- GED test preparation support
- Gym memberships and weight management programs

MCO Comparison Chart

Support Coordinators should assist CCMs with selecting a MCO by providing information on all six plans using *Appendix F – MCO Comparison Chart.*

What should a CCM expect after enrolling in an MCO?

Within 10 days of a member enrolling in Managed Care, the MCO will send the member a Welcome Packet including their Member Handbook and/or Welcome Letter. The MCO will also send the Member ID card.

Within 14 days of sending the Welcome Packet the MCO will call new members.

MCO Transition of Care

Support Coordinators are responsible for informing the CCM of the MCOs contractual obligation to ensure Transition of Care when enrolling in or switching MCOs.

MCOs Transition of Care Responsibilities

- MCOs do not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider. However, the MCO may require prior authorization of services beyond 30 calendar days.
- The MCO will honor any active prior authorization up to 30 days or until the transition of care is complete whether or not the authorization is with a in-network or out-of-network provider.

Enrollment / Disenrollment in Managed Care

Plan change effective dates are always on the first day of the month.

Any transfer request processed on or before the second to last business day of the month will be effective the following month.

Cutoff Date: Any transfer request processed on the last business day of the month will be effective on the second following month from the date of request.

Chisholm Class Members who have previously disenrolled from a MCO may reenroll in a MCO only during the annual open enrollment period* effective the earliest month that the action can be administratively taken.

*Members do not need a reason to change health or dental plans between October 15, 2024 and 6:00pm on December 2, 2024.

Enrollment / Disenrollment in Managed Care

Members may request disenrollment if:

- They are a new member. CCMs have a 90 day disenrollment period from the effective date of the enrollment during which they can change MCOs for any reason.
- After 90 days, CCMs will be locked in to the MCO until the next annual open enrollment period, unless they opt-out of managed care for their physical health services or show cause for disenrollment from the MCO.

Enrollment / Disenrollment Examples

September 2024

September 27 = second to last business day of the month.

Enrollment:

If you want to change your health plan or dental plan so your new plan starts **October 1, 2024**, you must make the change before **6:00pm** on **September 27, 2024**.

Cut Off:

If you make the change **after September 27, 2024**, your new health plan or dental plan will start on **November 1, 2024**.

www.myplan.healthy.la.gov gives current enrollment and cutoff dates.

Enrollment / Disenrollment

For more information on opting-in and disenrolling from managed care for physical health services:

- Refer to *Appendix S – Voluntary Opt-In to Managed Care for Chisholm Class Members.*
- Contact the Healthy Louisiana Line toll-free at 1-855-229-6848.

Changing Your MCO

Beneficiaries can change their health plan in 1 of these 5 ways:

Online: Log into their account or create one at MyPlan.healthy.la.gov/enroll

Mobile app: Download the Healthy Louisiana mobile app for free

Phone: Call at 1-855-229-6848 (TTY: 1-855-526-3346)

Fax: Send the enrollment form to 1-888-858-3875

Mail: Send the enrollment form to Healthy Louisiana, P.O. Box 1097, Atlanta, GA 30301-9913

MCO Member Services

Health Plan	Member Services Phone Number	TTY Phone Number
Aetna Better Health of Louisiana	1-855-242-0802	711
AmeriHealth Caritas Louisiana	1-855-756-0004	1-866-428-7588
Healthy Blue	1-844-521-6941	711
Humana Healthy Horizons	1-800-448-3810	711
Louisiana Healthcare Connections	1-866-595-8133	711
United Healthcare Community Plan	1-866-675-1607	711

https://www.myplan.healthy.la.gov/en/contacting-your-health-or-dental-plan

MCO Materials

Support Coordinators should familiarize themselves with the **Member Handbooks** for each MCO:

https://ldh.la.gov/page/member-handbooks

the **MCO Manual:**

https://ldh.la.gov/page/managed-care-organization-manual

and the **Chisholm Compliance Guide:**

https://ldh.la.gov/assets/HealthyLa/RFP21/ProcurementLibrary/Reference/ChisholmComplianceGuide.pdf

Medicaid Eligibility Verification

Medicaid Eligibility Verification System (MEVS) - MEVS is an electronic system used to verify Medicaid beneficiary eligibility and third party liability.

SCs are required to validate EPSDT beneficiaries Medicaid eligibility through MEVS **at the beginning of every month**. MEVS will provide the SC with current information on the beneficiary's Medicaid coverage including their MCO's information.

Medicaid Eligibility Verification

If the beneficiary becomes ineligible for Medicaid, they are no longer eligible for Support Coordination and closure procedures shall be followed.

If the beneficiary's Medicaid status has changed - including if their physical and/or behavioral coverage has changed - the SC must notify each provider of the change by the 5th of the month. If the provider does not accept the new coverage, the SC must notify the family and offer a freedom of choice list of providers in the new network.

Medicaid Eligibility Verification

The Support Coordinator must update the Physical and Behavioral MCO Agency in LSCIS as needed.

Statistical Resources, Inc. (SRI) will populate the **Physical MCO Agency** and the **Behavioral MCO Agency** fields in LSCIS based on the data file SRI receives from Gainwell Technologies.

If the fields are **pink**, SRI is populating them and the SC cannot edit them. Contact Kim if there are any discrepancies between LSCIS and MEVS.

- If the Physical MCO Agency field is blank, the beneficiary has Medicaid FFS for their physical health services.
- If the Behavioral MCO Agency field is blank, the beneficiary is enrolled in the Coordinated System of Care (CSoC).

If the fields are **white**, SRI is not populating them and the SC must enter and update the Physical and Behavioral MCO Agency into LSCIS as needed.

Medicaid Eligibility Verification

The SC must update the Medicaid Identification number in LSCIS as needed.

SCs must compare the beneficiary's Medicaid number from the Medicaid Eligibility Verification System and the number entered in LSCIS. Discrepancies should be reviewed and corrected.

If Statistical Resources, Inc. needs to correct the Medicaid number on the EPSDT SC Prior Authorization, submit a copy of the MEVS to Kim Willems via e-mail at ksalling@statres.com.

Who Covers What?

Once the SC determines who covers the beneficiary's physical health, specialized behavioral health and transportation services they can determine who will administer/cover specific Medicaid services for the beneficiary.

Some Medicaid services such as Personal Care Services require prior authorization (PA) before they can be provided. Prior Authorization is a requirement that a provider obtains approval from the beneficiary's health insurance *before* providing a particular service. Prior Authorization is also known as pre-approval.

PA decisions are reached based on the **medical necessity** of the request.

Who Covers Physical Health Services?

P-Linkage or CSoC children = MCO for physical health
PA requests are acted on by the **individual MCO**.

B-Linkage = FFS for physical health
PA requests are acted on by the Fiscal Intermediary (FI), **Gainwell Technologies**, a company that contracts with the Louisiana Department of Health to perform this function.

Who Covers Specialized Behavioral Health Services (SBHS)?

B-Linkage or P-Linkage = MCO for SBHS

PA is required for some SBHS services including but, not limited to :

- Community Psychiatric Support and Treatment (CPST) including but, not limited to:
  - Multi-Systemic therapy (MST),
  - Functional Family Therapy (FFT),
  - Homebuilders (HB),
  - Assertive Community Treatment (ACT),
- Psychosocial Rehabilitation (PSR),
- Therapeutic Group Homes (TGH),
- Psychiatric Residential Treatment Facilities (PRTF), and
- Substance Use Disorder (SUD) residential services.

CSoC Children = Magellan of Louisiana for SBHS

Magellan of Louisiana, the contractor for CSoC, will authorize SBHS for CSoC children. The SC is not required to do PA tracking for services authorized by Magellan of Louisiana. The MCO will authorize Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Homes (TGH), and Substance Use Disorder (SUD) Residential services.

Who Covers What?

Transportation Services = MCO

The beneficiary's Managed Care Organization will cover medical transportation services including NEMT/NEAT.

No prior authorization is required.

Who Covers What?

Applied Behavioral Analysis = MCO

PA requests are acted on by the **individual MCO**.

Who Covers What?

Carved-out Benefits = FFS

These services will be paid by the Louisiana Department of Health (LDH) on a fee-for-service (FFS) basis for all beneficiaries:

- Nursing Facility for long-term care
- Services provided through LDH's EarlySteps Program
- School-based services provided by a school district through a written plan of care (IEP, IFSP, 504 plan, etc.)
- All Home and Community-Based Waiver Services
- Targeted Case Management Services
- Dental benefits – Prepaid Ambulatory Health Plan (PAHP) / Dental Plan info is on slide 178.
- CSoC – Magellan of Louisiana is CSoC contractor. CSoC info is on slides 63-67.

MCO members may obtain excluded services under the Louisiana State Plan or Fee-For-Service Medicaid, however, the MCO will not pay for these services. MCOs are responsible for informing members how to access services that are excluded from MCO covered services and continue to be provided through FFS.

Part 2

SERVICES AVAILABLE TO EPSDT BENEFICIARIES

Goals of Support Coordination

Beneficiaries under the age of 21 with disabilities and/or chronic health conditions typically need more Medicaid services than their peers without disabilities or health concerns do. Parents of youth with developmental disabilities are sometimes unaware of the services that may be available to assist them. **Therefore, it is important for the Support Coordinator to be knowledgeable of these services and how to access them.**

As the Support Coordinator, it is your responsibility to make suggestions for these services. Do not wait for the family to request a service**. If you see a need for one of these services, inform the family and document their response.**

If the child may need additional services, but it is not clear, **suggest appropriate evaluations** to determine whether there is a need. If the family states they aren't interested in the service, accept that. However, feel free to remind the parent of the service again when the opportunity presents.

Goals of Support Coordination

A Support Coordinator develops a full list of all the services a beneficiary needs and then helps them get and coordinate these necessary services.

Parents often do not understand aspects of the Medicaid system.

Therefore, one of the primary responsibilities of the Support Coordinator is to follow through with requests for services until the Prior Authorization is either approved or denied based on medical necessity and when approved, make sure the services are provided as authorized. The SC is responsible for coordinating all identified service needs, including Medicaid services that do not require a PA, paid and un-paid supports, as well as non-Medicaid services. The SC must follow up to ensure services are received.

Services Available to EPSDT Beneficiaries

Youth receiving targeted EPSDT Support Coordination are eligible to receive **all medically necessary Medicaid services** that are available to individuals under the age of 21.

Specialized Behavioral Health Services are administered under the authority of the Louisiana Department of Health in collaboration with the Managed Care Organizations, as well as through the Coordinated System of Care (CSoC) program contractor, Magellan of Louisiana, for members enrolled in CSoC.

In addition if they are placed on the DD RFSR, they may be eligible for services through the Louisiana **Developmental Disabilities services system**, administered by OCDD through the local governing entities (LGE). LGEs also provide outpatient behavioral health services.

Youth may be able to receive services through the **school system** or through Early Childhood Education programs.

The Medicaid EPSDT Benefit

Section 1905(a)(4)(B) and (r) of the Social Security Act entitles eligible children under age 21 to Medicaid coverage of health care, diagnostic services, treatment, and other measures as described in section 1905(a) that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are covered under the state plan.

The Medicaid EPSDT Benefit

EPSDT is more robust than the Medicaid benefit for adults and all Medicaid coverable, medically necessary services must be provided even if the service is not available under the State plan to other Medicaid eligibles.

Medical necessity is determined on a **case-by-case basis**.

No arbitrary limitations on services are allowed. There are no fixed limits on the amounts of services beneficiaries under age 21 can receive. They are entitled to as many doctor visits, and as many hours and amounts of any other services as are medically necessary for their individual conditions.

Some Medicaid services must be **“prior authorized (PA)”** before the service can be provided.

The Medicaid EPSDT Benefit

Medicaid-offered services are more comprehensive than services offered through schools as part of a child's written plan of care (Individualized Educational Program (IEP), IFSP, 504 plan, etc.). Written plans of care only cover services that help with a child's *education.* Medicaid, outside of the written plan of care process, covers services needed to help any other aspect of a child's life, as well.

The Medicaid EPSDT Benefit

For a listing of available Medicaid services, consult *Appendix D – Services Available to Medicaid Eligible Children Under 21* and *Appendix E - Medicaid Services Chart.*

The EPSDT-Targeted Support Coordination Training Handbook also provides detailed information about specific services.

Even if a service is not listed on the Medicaid services chart, it must still be covered if it is a service permitted by federal Medicaid law and is medically necessary to correct or ameliorate a physical or mental condition of a beneficiary who is under age 21.

The current Medicaid Services Chart can be found at: https://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

The Medicaid EPSDT Benefit

Some services, which Medicaid eligible children can access, but that are not available to those ages 21 or older, or are only available under certain circumstances are:

- EPSDT Support Coordination
- Psychological evaluations and therapy
- Psychiatric hospital care
- Medical, dental, vision and hearing screenings, both periodic and interperiodic
- Audiological services
- Speech and language evaluations and therapy
- Occupational therapy
- Physical therapy
- Personal Care Services (PCS)

The Medicaid EPDST Benefit

- Skilled Nursing (intermittent or part-time)
- Extended Skilled Nursing Services (EHH)
- Pediatric Day Health Care (PDHC)
- Dental care
- Hearing aids and supplies needed for them
- Eyeglasses
- Medical Equipment, Appliances and Supplies (DME)
- Applied Behavioral Analysis (ABA)
- **Any item or service that is medically necessary to correct or ameliorate health conditions of the child**, regardless of whether the item or service is covered by the State plan, which includes a wide range of services not covered for individuals over the age of 21.

Applied Behavioral Analysis (ABA)

ABA therapy is a set of behavior treatments that work to increase useful or desired behaviors.

ABA therapy:

- teaches skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior.
- increases language and communication skills, to improve attention, focus and social skills, and to reduce problem behaviors.
- is based on reliable evidence of it's success in alleviating autism and is not experimental. ABA applies scientific principles about learning and behavior to reduce behaviors that may be harmful or interfere with learning.

Applied Behavioral Analysis (ABA)

ABA-based services are available to Medicaid beneficiaries under 21 years of age who:

- Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include: aggression, self-injury, elopement, etc.)
- Are diagnosed by a qualified health care professional (QHCP) with a condition for which ABA-based therapy are recognized as therapeutically appropriate, including autism spectrum disorder.
- Have a comprehensive diagnostic evaluation (CDE) by a qualified health care professional (Note: may be able to use a recent psychological evaluation, psychiatric evaluation, Special Education Evaluation, IEP, etc., if ABA is recommended) and
- Have a prescription for ABA-based therapy services ordered by a qualified health care professional. (Note: If there is a recommendation in the CDE for ABA therapy, a separate prescription is not needed.)

Applied Behavioral Analysis (ABA)

To find an ABA Provider in your area, call the beneficiary's MCO.

If a beneficiary wants to see if they qualify for ABA, contact the beneficiary's MCO and complete a referral for a Clinical Diagnostic Evaluation (CDE). The SC should assist the beneficiary in contacting the MCO to ask that they arrange a CDE and should document this request in the service log.

For more information on ABA contact the beneficiary's MCO or LDH directly at 1-844-423-4762 and refer to the EPSDT SC Handbook – Applied Behavioral Analysis-Based Therapy Services section.

Transportation Services

Non-emergency medical transportation (NEMT) plays an essential role in enabling access to medically necessary services. NEMT provides transportation to and/or from medical services covered by Medicaid when no other means of transportation is available.

All beneficiaries may access this service through their MCO.

The transportation phone numbers for each MCO can be found on *Appendix C – MCO Service and Equipment Flyer* or https://ldh.la.gov/page/medical-transportation.

Transportation Services

Children under 17 must be accompanied by an **attendant**. The only exception to this rule are for all females, regardless of their age, seeking prenatal and/or postpartum care.

If a child is to be transported, either as a beneficiary or an additional passenger, the parent or guardian of the child is responsible for providing an appropriate **child passenger restraint system** as required in all cars. The transportation providers will not transport any child without the appropriate child passenger restraint system.

With the exception of urgent transportation requests and discharges from inpatient facilities, arrangements for non-emergency transportation should be made at least **48 hours** in advance. The 48 hour minimum does not include non-business days.

Transportation Services

Transportation must be provided in all parishes and to all eligible beneficiaries. If there is a need for special arrangements, such as lift-equipped transportation, the MCO must ensure that such arrangements are made promptly so that the beneficiary can obtain the medical services they need.

The role of the Support Coordinator is to offer, and provide if requested, necessary assistance with scheduling appointments for, and transportation to, services. This should be documented in the case record.

Transportation Services

Non-emergency ambulance transportation (NEAT) provides an eligible Medicaid beneficiary transportation by ground or air ambulance to and/or from medical services covered by Medicaid when no other means of transportation is available and the beneficiary's condition is such that use of any other method of transportation is contraindicated or would make the beneficiary susceptible to injury. **The nature of the trip is not an emergency, but the beneficiary requires the use of an ambulance.**

All NEAT trips will require a completed, valid Certification of Ambulance Transportation (CAT). The beneficiary's treating physician, a registered nurse, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition, which necessitates ambulance services.

Gas Reimbursement Transportation Program

Louisiana Medicaid will allow family members or friends of an eligible beneficiary to act as a gas reimbursement provider will transport the beneficiary to and/or from Medicaid covered services and additional services approve by the beneficiary's assigned health plan. The program allows the individual participating as the gas reimbursement transportation provider to be reimbursed by the health plan based on the total milage of each trip.

In order to participate as a gas reimbursement provider the individual must be 18 years of age or older and may not reside at the same address as the beneficiary. The beneficiary may not act as a gas reimbursement provider and transport themselves to appointments.

If a beneficiary you are serving may benefit from this program, the SC should obtain approval by contacting the transportation broker affiliated with the beneficiary's assigned health plan. Refer to *Appendix C – MCO Service and Equipment Flyer* or https://ldh.la.gov/page/medical-transportation.

BEHAVIORAL HEALTH SERVICES

Coordinated System of Care (CSoC)

CSoC was developed for Louisiana's youth with significant mental health disorders that are in or at imminent risk of out of home placement.

CSoC offers an array of Medicaid State Plan and Home and Community-Based Waiver services (HCBS) to youth in need of mental health and/or substance use treatment who are deemed clinically and financially eligible.

CSoC is an evidence-informed approach that enables youth to successfully live at home, stay in school and reduce involvement in the child welfare and juvenile justice systems.

Coordinated System of Care (CSoC)

CSoC might be right if the youth:

- Is 5 - 20 years old,
- has a mental health or co-occurring disorder,
- has a history with child welfare, juvenile justice and/or trouble in school, and
- is at risk or in an out-of-home placement including:
  - Substance Use Disorder treatment facilities
  - Detention
  - Developmental disabilities facilities
  - Homeless (as identified by the Department of Education)
  - Non-medical group home
  - Psychiatric Hospitals
  - Psychiatric Residential Treatment Facilities
  - Secure care facilities
  - Therapeutic foster care
  - Therapeutic Group Home

Coordinated System of Care (CSoC)

Partners play a very important role in the success of CSoC. CSoC intends to ensure that efforts on behalf of youth and families are integrated across systems. CSoC is a family driven process. Therefore, referrals should be made with parent's/guardian's knowledge, consent and participation.

To make a referral for CSoC:

- Call Magellan's direct referral line at 1-800-424-4489 or call the beneficiary's MCO with the parent/guardian present or on the phone.
- Magellan or the MCO will ask initial risk questions. If the MCO was called, they will transfer the call to Magellan if the child meets criteria.
- Magellan will conduct a brief Child and Adolescent Needs (CANS) assessment to establish preliminary eligibility.

Coordinated System of Care (CSoC)

If, based on the CANS assessment, a youth is eligible for CSoC, Magellan will refer the youth to a **Wraparound Agency** to ensure that a comprehensive assessment is completed, offer the youth and the family an opportunity to participate in CSoC and begin forming a Child and Family Team (CFT).

Regardless of CSoC eligibility, their Managed Care Entity (MCO or Magellan) will ensure that the youth is referred to providers who can meet their needs.

Coordinated System of Care (CSoC)

Youth enrolled in CSoC are assigned a worker called a**Wraparound Facilitator**. The youth and family will work with the facilitator to develop a plan of care with a team of people. The plan can include services and supports to meet their behavioral health needs as well as other needed services and supports that affect their wellbeing.

Coordinated System of Care (CSoC) enrollees may receive these**additional** services:

- ❑Parent Support and Training
- ❑Youth Support and Training
- ❑Short Term Respite Care
- ❑Independent Living and Skills Building

If a beneficiary is part of Coordinated System of Care (CSoC), they can access specialized behavioral health services by contacting **Magellan** at 1-800-424-4489/TTY 1-800-424-4416.

Behavioral Health Services

The following Specialized Behavioral Health Services are available to all Medicaid eligible youth under age 21 who have a medical need:

Licensed Practitioner Outpatient Therapies:

- Assessments, evaluations and testing
- Individual, group and family therapy
- Parent-Child Interaction Therapy (PCIT)
- Child Parent Psychotherapy (CPP)
- Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)
- Triple P Positive Parenting Program (Triple P)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Eye Movement Desensitization and Processing Therapy (EMDR)
- Dialectical Behavior Therapy (DBT)

For more information visit laevidencetopractice.com and refer to the Handbook. SBHS will either be accessed through the beneficiary's MCO (P-Linkage or B-Linkage) or through Magellan if the youth is enrolled in the CSoC Waiver.

Behavioral Health Services

The following Specialized Behavioral Health Services are available to all Medicaid eligible youth under age 21 who have a medical need:

Mental Health Rehabilitation (MHR) services include:

- Community Psychiatric Support and Treatment (CPST)*
  - Multi-Systemic Therapy (MST)*
  - Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare (FFT-CW)*
  - Homebuilders®*
  - Assertive Community Treatment (ACT) (ages 18-20)*
- Psychosocial Rehabilitation (PSR)*
- Crisis Intervention (CI)

*The beneficiary's MCO must prior authorize some specialized behavioral health services including, but not limited to, CPST – including but not limited to MST, FFT/FFT-CW, HB, and ACT – and PSR. CSoC youth will access these services through the CSoC Contractor, Magellan of Louisiana, and may be subject to prior authorization but, do not require PA tracking by the SC.

Behavioral Health Services

The following Specialized Behavioral Health Services are available to all Medicaid eligible youth under age 21 who have a medical need:

- Mobile Crisis Response (MCR)
- Crisis Stabilization (CS)
- Community Brief Crisis Support (CBCS)
- Outpatient Substance Use Disorder services
- Opioid Treatment Programs (OTP)

SBHS will either be accessed through the beneficiary's MCO (P-Linkage or B-Linkage) or through Magellan if the youth is enrolled in the CSoC Waiver.

Behavioral Health Services

- **Residential and hospital-based behavioral health treatment services:**
  - Therapeutic Group Home (TGH)*
  - Psychiatric Residential Treatment Facility (PRTF)*
    - A certificate of need is required prior to admission to a PRTF.
  - Inpatient Hospitalization
  - Residential Substance Use Disorder services*

*The beneficiary's MCO must prior authorize some SBHS including, but not limited to, TGH, PRTF and Residential Substance Use Disorder services. CSoC enrollees will also access TGH, PRTF and Residential Substance Use Disorder services through their MCO.

School-Based Behavioral Health Services

Medicaid also funds behavioral health services provided through schools or early childhood educational settings for children ages 3 to 21 years, such as regular kindergarten classes; public or private preschools; Head Start Centers; child care facilities; or home instruction. To be funded by Medicaid, these services must be included in the child's written plan of care (Individualized Education Program (IEP), IFSP, 504 plan, etc.). Behavioral Health services, treatment, and other measures to correct or ameliorate an identified mental health or substance use disorder diagnosis may be provided by licensed mental health practitioners or Louisiana Certified School Psychologists and Counselors.

PHYSICAL HEALTH SERVICES

EPSDT Screening Services

Medicaid beneficiaries under the age of 21 are eligible for well-child visits known as screening services.

Screening services include:

- a comprehensive health and developmental history;
- physical exam;
- immunizations;
- laboratory tests, including lead blood level assessment;
- vision and hearing checks;
- developmental screening;
- autism screenings;
- perinatal depression screening;
- dental screenings; and
- health education.

EPSDT Screening Services

Screening services are available both on a regular basis, and whenever additional health treatment or additional services are needed.

Louisiana uses the Bright Futures periodicity schedule developed by the American Academy of Pediatrics to determine recommended intervals for screening services. The **periodicity schedule** can be found here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

In addition, an **interperiodic screen** can be obtained whenever one is requested by the parent or is recommended by a health, developmental, or educational professional (including a Support Coordinator), in order to determine the existence of certain physical or mental illnesses and determine a child's need for health treatment or additional services.

There are no limits on the number of visits that are **medically necessary** for the beneficiary's condition.

EPSDT Screening Services

Well-child visits, referred to as screening services, are the foundation of EPSDT coverage and are a crucial entry point for identifying concerns and conditions that require follow-up care.

These visits are intended to be comprehensive and include age-appropriate screenings, referrals to diagnostic and specialty services, and referrals to establish ongoing dental, vision, and hearing care. **Primary care providers are responsible for making appropriate referrals when needed based on the results of a screening.**

When detected early medical conditions such as lead poisoning, sickle cell anemia, developmental delays, nutritional deficiencies, and behavioral disorders consistently result in successful outcomes and cost effective treatment plans. It is crucial to identify disabilities early so that you can get treatment early.

Screening & Diagnosis is the crucial link to necessary covered treatment.

Personal Care Services

Personal Care Services (PCS) are provided by direct service workers and defined as tasks that are medically necessary as they pertain to an EPSDT beneficiary's physical requirements when cognitive or physical limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements. Assistance is provided with meal preparation if the beneficiary is on a restricted diet that differs from the rest of the household members and no family member is preparing the meals.

PCS **does not include medical tasks** such as medication administration, tracheotomy care, feeding tube or catheter requirements. Assistance with these tasks can be covered through Medicaid's Home Health program. Refer to *Appendix G – EPSDT PCS vs. Home Health and PCS Rule Information*.

PCS is not intended as a substitute for child care needs or to provide respite care to the primary caregiver.

A parent or adult caregiver is **not required** to be in the home while services are being provided to children.

How is PCS authorized?

Personal Care Services must be prior authorized by Gainwell Technologies (FFS) or the MCO.

The provider must complete a Social Assessment form, a daily time schedule and develop a plan of care.

A practitioner must complete an EPSDT-PCS Form 90 to prescribe or refer the service, and sign the provider's plan of care: https://www.lamedicaid.com/provweb1/forms/EPSDT_pcs_form_90.pdf

The number of hours approved is based on assistance with the personal care needs that are covered through this program. There are **no set limits** to the number of hours a beneficiary can receive.

The Support Coordinator should assure that the practitioner has all critical information before the services are prescribed.

All PA requests should include necessary documentation to support the medical necessity of the request.

Extended Home Health Services

What is Extended Skilled Nursing Services also known as Extended Home Health (EHH)?

- Extended Skilled Nursing Services is nursing care provided to beneficiates under the age of 21 who are considered “medically fragile.”
- Extended Skilled Nursing Services must be prior authorized unless the visit is less than 3 hours per day.
- A prescription is needed from the authorizing healthcare provider stating the number of hours requested and a letter of medical necessity justifying the reason for Extended Skilled Nursing Services.

Home Health Services for youth are **not limited** in terms of frequency or duration but are based on medical need.

Other Home Health Services

Skilled Nursing (Intermittent or part-time)

- Needs for less than three hours of nursing care per day
- Can be prescribed by an authorizing healthcare provider and obtained without prior authorization for beneficiaries aged 0 through 20. These services must still be ordered by an authorized healthcare provider and provided by a Home Health services provider.

Home Health Aide Services

Rehabilitation Services

- are physical, occupational and speech therapies, including Audiology services that can be provided in the home, an outpatient facility, an Early Intervention Center, a rehabilitation center and at school.
- All rehabilitation services must be prior authorized.

Pediatric Day Health Care (PDHC)

Serves medically fragile individuals under the age of 21, including technology dependent children, who require close supervision.

PDHC facilities offer an alternative health care choice or supplement to receiving in-home nursing care.

PDHC may be provided up to seven days per week and up to 12 hours per day as documented by the beneficiary's Plan of Care.

Care and services to be provided shall include but shall not be limited to: (a) Nursing care, including but not limited to tracheotomy and suctioning care, medication management, and IV therapy, and gastrostomy care. (b) Respiratory care. (c) Physical, speech, and occupational therapies. (d) Assistance with activities of daily living. (e) Transportation to and from the PDHC facility.

Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services

For Medicaid to cover these services at school (ages 3 to 21), they must be part of the child's written plan of care (Individualized Education Program (IEP), Individualized Family Support Plan (IFSP), 504 plan, etc.)

For Medicaid to cover these services through an outpatient facility, in a rehabilitation center, or home health, they must be ordered by a physician and must be prior authorized by Gainwell Technologies (Medicaid FFS). Check with the MCO to determine if the MCO requires prior authorization.

Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services

The Support Coordinator is to explain to the individual that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the child's written plan of care (IEP, IFSP, 504 plan, etc.).

The Support Coordinator is to ask the beneficiary if they want to receive any medically necessary therapies outside of the school setting, in addition to those they receive in school. The beneficiary should also be asked if they want to receive therapies during the school's summer break.

The Support Coordinator helps the family to determine the setting in which the child will receive the greatest benefit, and also helps the family by making the appropriate referral and coordinating the days and times of this service with other services the beneficiary is receiving and monitoring the delivery of the services.

Medical Equipment and Supplies

Beneficiaries are entitled to any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions.

This includes lifts and other devices to help the family deal with a child's circumstances such as communication devices, and also some medically necessary dietary or nutritional assistance.

Medical Equipment and Supplies must be prescribed by a physician and prior authorized by Gainwell Technologies (Medicaid FFS). Check with the MCO to determine if the MCO requires prior authorization.

Medical Equipment and Supplies

Disposable incontinence supplies for children age 4 through 20:

Based on medical necessity, diapers, pull-on briefs, and liners/guards may be covered.

Refer to *Appendix BB-1 – PA Request Forms and Physician Forms* or https://www.lamedicaid.com/provweb1/forms/PAforms.htm

Medical Equipment and Supplies

The FFS or MCO prior authorization unit may approve **less expensive items** that it believes will meet a beneficiary's needs. If so, the notice of denial should identify the items.

- The beneficiary can accept the less costly item and still appeal the denial of the item originally requested; however, they must not dispose of, destroy, or damage (beyond normal wear and tear) the less expensive item while the appeal is pending.
- You should consult with the beneficiary and the provider to see if the less costly item identified will work, and help the beneficiary decide whether to appeal for the item originally requested.
- The support coordinator must explain appeal rights to the family and assist in the appeal if the beneficiary wants that help.

Other Medicaid Services Not Listed

Refer to *Appendix D – Services Available to Medicaid Eligible Children Under 21* for an expanded list of available services.

To ask about other available services:

- FFS – contact the Specialty Care Resource Line at 1-877-455-9955 or TTY 1-877-544-9544
- MCO – contact the beneficiary's MCO Member Services line or the beneficiary's Medicaid Managed Care Case Manager.

Although a service may not be listed, if it is a service permitted by federal Medicaid law, and is necessary to correct or ameliorate a physical or mental condition of a beneficiary who is under age 21, it must be covered. Persons under age 21 are entitled to receive all equipment that is medically necessary. This includes many items that are not covered for adults. These services may be subject to the restrictions allowable under Federal Medicaid law.

NON-MEDICAID SERVICES

Non-Medicaid Services

Many non-Medicaid sources of supports and services are available, such as:

- OCDD local governing entities (LGE)
  - Flexible Family Funds (Cash Subsidy)
  - Individual and Family Support
  - Local Governing Entity Support Coordination
  - Refer to Handbook – OCDD Services section and *Appendix J-1 – LGE Directory.*

Non-Medicaid Services

- LGE Services
  - LGE Community Behavioral Health Services
  - CART (child/adolescent response teams)
  - Refer to the Handbook – OCDD Services section and *Appendix J-3 – LGE Community Behavioral Health Services.*
- Services Available through School Systems
  - Each school system in Louisiana has a Child Search Coordinator who can arrange for evaluations of children to determine whether or not the child has a disability and requires special educational services.
  - Refer to Handbook – Services Available though School Systems section.
- Other community services

Home and Community Based Waivers for People with Developmental Disabilities

Most children currently receiving EPSDT Support Coordination services are on the Developmental Disabilities Request for Services Registry (DD RFSR).

Home and Community Based Waivers for People with Developmental Disabilities

Residential Options Waiver (ROW) – which offers expanded home and community based services for individuals of all ages.

New Opportunities Waiver (NOW) – which provides comprehensive home and community based services for individuals age 3 or older.

Children's Choice Waiver (CC) – which provides a limited package of services to children under the age of 21.

Supports Waiver (SW) – which provides supports and services for a meaningful day including employment and community life engagement.

Refer to *Appendix I – Waiver Fact Sheets (ROW, NOW, CC, SW).*

Know the Facts about Children's Choice

Children's Choice Waiver opportunities shall be offered to individuals under the age of 21 who are on the registry and have the highest level of need.

Services are capped at $20,650 per care plan year and can be used for medical care, home and vehicle modifications, caregiving assistance and support, and other specialty services.

When the family chooses to accept Children's Choice, the child's name is taken off the Developmental Disabilities Request for Services Registry (DD RFSR).

Youth who reach the age of 18 and want to work may choose to transition to a Supports Waiver as long as they remain eligible for waiver services. Youth who continue in the Children's Choice Waiver beyond age 18 will age out of Children's Choice Waiver when they reach their 21st birthday. They will transition to the most appropriate waiver that meets their needs as long as they remain eligible for waiver services.

What Happens at Age 21?

Because states are not required to cover optional section 1905(a) benefits for adults, some services may no longer be available when beneficiaries turn 21 years old, such as support coordination, EPSDT Personal Care Services, Extended Home Health Services and incontinence supplies. If possible, the SC should identify alternatives during this critical time.

The SC should be aware of available services and make arrangements to transition the beneficiary to receive all services he or she may need in order to continue to live in the most integrated setting that is appropriate for him or her.

Planning should begin well in advance of a beneficiary's transition. The SC should begin making arrangements for transition at least 6 months prior to the beneficiary's 21st birthday.

What Happens at Age 21?

Providers may need to be changed if the current provider only serves children. The SC should coordinate appointments, transfer medical records, and connect families with new health care providers.

The SC should facilitate the development of a CPOC that outlines the transition process, including referrals to appropriate providers and services.

EPSDT transition strategy must be addressed in the Additional Information section: to be informed of the change in Medicaid services for adults, LT-PCS, OCDD services, how to obtain the services they now receive, link to resources to receive those services, and encouraged to obtain exams, eyeglasses, DME, etc. prior to aging out.

What Happens at Age 21?

Available services may include:

- **OCDD services**, including extended family living, supported independent living, and vocational and rehabilitative services. Refer to Appendix J-1 – LGE Directory.
- **Long Term-Personal Care Services (LT-PCS)** through Medicaid - Beneficiaries who are receiving EPSDT-PCS will be contacted by Conduent regarding LT-PCS. The support coordinator should inform the family to expect notification via phone or mail. Call 1-877-456-1146 (TDD 1-855-296-0226) for additional information.
- **Louisiana Rehabilitation Service (LRS)** may provide assistance with services needed to pursue short or long-term employment goals including higher education. Call 1-800-737-2958 for additional information.
- **Office of Aging and Adult Services (OAAS)** - Community Choices Waiver and Adult Day Health Care Waiver: if they have a Statement of Denial from OCDD such as those receiving Special Needs Support Coordination. Call 1-877-456-1146 to request to be placed on the Request for Services Registry.

Part 3

COMPONENTS OF SUPPORT COORDINATION

Assessment and Reassessment

Support Coordination includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - Taking client history;
  - Identifying the beneficiary's needs and completing related documentation; and
  - Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the beneficiary.

  After the initial assessment is completed, reassessments are done on a quarterly basis, at a minimum, and as needed when significant changes in circumstances occur.

Intake

Contact the beneficiary and/or legal guardian within 3 business days of the referral to the Support Coordination Agency (Linkage/FOC).

At that time, a face-to-face in-home appointment should be set up within 10 calendar days to discuss what support coordination is and how it can benefit the individual.

The individual should be asked about formal information documents they may have or can obtain prior to the CPOC assessment, including the current IEP, current PDHC Plan of Care, and/or current EHH Plan of Care.

Intake

The Support Coordination Choice and Release of Information Form (Linkage/SC FOC) must be used to obtain all plans, evaluations, assessments and documents that OCDD has developed or used in connection with its determination that the beneficiary is eligible for services through the developmental disability services system including the Statement of Approval (SOA).

Allow OCDD a five work day turnaround.

Refer to *Appendix K – EPSDT Support Coordination FOC (Sample)* – Section 2: Release of Information.

Intake

The support coordinator shall use MEVS to determine if the beneficiary is eligible and remains eligible for Medicaid.

The support coordinator shall check for continued eligibility monthly. If the beneficiary becomes ineligible for Medicaid, they are no longer eligible for Support Coordination and closure procedures shall be followed as identified in the Transition/Closure section of the Handbook.

At the Face-to-Face Visit

A face-to-face in-home visit must be conducted within 10 calendar days of the referral to the Support Coordination Agency (Linkage/FOC).

Determine if the individual accepts Support Coordination and agrees with the contact requirements, including the required face-to-face meetings.

The individual is often overwhelmed with everything they are being told in this first meeting. Do not expect the individual to remember everything, even if you are providing information in writing.

REVIEW THIS INFORMATION

AS OFTEN AS IS NECESSARY

At the Face-to-Face Visit

The SC must explain and review the following with the individual:

- ***Appendix D - Services Available to Medicaid Eligible Children Under 21***
- ***Appendix E - Medicaid Services Chart –*** Explain and review, with special emphasis on medical equipment and supplies, EPSDT-PCS and home health.
- ***Appendix O - Rights and Responsibilities***
- ***Appendix L - EPSDT Support Coordination Blank CPOC and Typical Weekly Schedule***
  - CPOC signature page - everyone present at the meeting must sign in planning participant's box.
  - Typical Weekly Schedule – include services received and requested
- ***Appendix P - Appeal Brochure***
- ***Appendix Q - Complaint Form*** - Complaint Process for filing a report against support coordinators and/or FFS providers
- ***Appendix R - Managed Care Complaints*** - Complaint Process for filing a report against Managed Care Organizations or MCO providers
- ***Appendix S – Voluntary Opt-In to Managed Care for Chisholm Class Members -*** Discuss with Chisholm Class Members their right to choose between FFS and MCO their physical health services
- **HIPAA & Confidentiality Notification**
- **Referral to EPSDT Screening provider** (if requested)
- **Availability of formal and non-formal services**

Assessment

- Must begin within 7 calendar days of linkage and prior to the CPOC meeting.
- Assessment is the process of gathering and integrating formal and informal information relevant to the development of a person centered CPOC.
- Formal information includes medical, psychological, pharmaceutical, social, educational information, and information from OCDD.
- Informal information includes information gathered in discussions with the family and beneficiary and may also include information gathered from talking to friends and extended family.

Assessment

The SC is to obtain:

- all assessments/evaluations and documents that OCDD used to determine eligibility,
- the current IEP,
- the current Home Health Plan of Care,
- the current Pediatric Day Healthcare Plan of Care, and
- any other assessments by professionals (EPSDT-PCS Form 90, LRS and Special Education Evaluations, behavior plans, psychological and other evaluations, etc.) that are required to obtain CPOC approval.

The SC is to contact OCDD, schools, Pupil Appraisal and health care professionals for necessary records, ask the individual about documents they may have or can obtain from their school, and follow up on requests for records.

The SC is encouraged to collaborate with Local Educational Agencies to enhance comprehensive coordination of Medicaid services across settings.

Assessment

The Support Coordinator may need to assist the beneficiary with arranging professional evaluations and appointments including well-child visits/EPSDT screening services and follow-up evaluations. The information provided as a result of these visits could prove critical in the assessment that will be used to develop the beneficiary's person-centered Comprehensive Plan of Care.

Development of the CPOC

Support Coordination includes the following assistance:

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the beneficiary;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual.

The Comprehensive Plan of Care (CPOC) is the Support Coordinator's blueprint for assisting the individual and is developed through a person-centered planning process. Person Centered Planning is planning lead by the individual designed to meet the individual's needs.

Comprehensive Plan of Care (CPOC)

The CPOC must be completed in a face-to-face in-home meeting with the individual's support team. **The individual and the legal guardian must be present.**

The support team is made up of the individual, legal guardian, Support Coordinator, and other people chosen by the individual that know them best such as family, friends or other support systems, or direct service providers. All references to the individual include the role of the individual's representative.

Everyone present at the meeting must sign the CPOC Participants Signature Page in the Planning Participants box.

Competent Major

Determine if the beneficiary is a competent major. A competent major is 18 years of age or older and has not been legally declared incompetent.

- If the competent major is able to express their preferences, the Support Coordinator should talk directly to the competent major and have them sign all documents. A competent major may choose to have an authorized representative by completing the *Appendix M – Authorized Representative Form.*
- If the competent major is unable to express their preferences due to a disability for which an accommodation cannot bridge the gap, the Support Coordinator should document why they believe the competent major is not able to direct their own care and must obtain an Authorized Representative form *(Appendix M)* or a supported decision-making (SDM) agreement.

Refer to Handbook – Establishing the Support Team section for more information on authorized representatives and support decision-making.

Comprehensive Plan of Care (CPOC)

The CPOC is based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the individual.

The CPOC must include agreed upon strategies to achieve or maintain the personal outcomes using appropriate natural, community supports, non-formal, and formal paid services.

The CPOC must include timelines in which the personal outcomes can be met or at least reviewed (minimum requirement is quarterly).

The Support Coordinator is responsible for providing complete and clear information to assure the individual can make informed choices regarding the supports and services they receive and from whom. During the CPOC meeting, the Support Coordinator must use *Appendix E - Medicaid Services Chart* to discuss the available Medicaid services.

Comprehensive Plan of Care (CPOC)

Do not wait for the individual to request a service. **If you see a need for a service, offer the service to the individual and document their response** (requested, declined, on hold).

If the individual may need additional services, but it is not clear, suggest appropriate evaluations to determine whether there is a need.

One of the primary responsibilities of the Support Coordinator is to follow through with requests for services.

Comprehensive Plan of Care (CPOC)

The CPOC is to be completed electronically in Louisiana Support Coordinator Information System (LSCIS). The SC should review a blank copy of the CPOC and the instructions before conducting each CPOC.

The CPOC is designed to briefly summarize important information so that it can be reviewed and considered in evaluating the need for proposed services and supports.

Information relevant and applicable to justifying services requested by the individual must be provided.

Information critical to the individual's health and safety should be documented in the CPOC.

The CPOC should always emphasize the individual's personal outcomes. The goal is to provide support and services in a person focused, cost effective and accountable manner.

Comprehensive Plan of Care (CPOC)

The CPOC is comprised of the following six sections:

- Section 1 - Contact Information / Demographic Information
- Section 2 – Medical / Social / Family History
- Section 3 - CPOC Service Needs and Supports
- Section 4 - CPOC Participants
- Section 5 - CPOC Approval
- Section 6 - Typical Weekly Schedule (paper form)

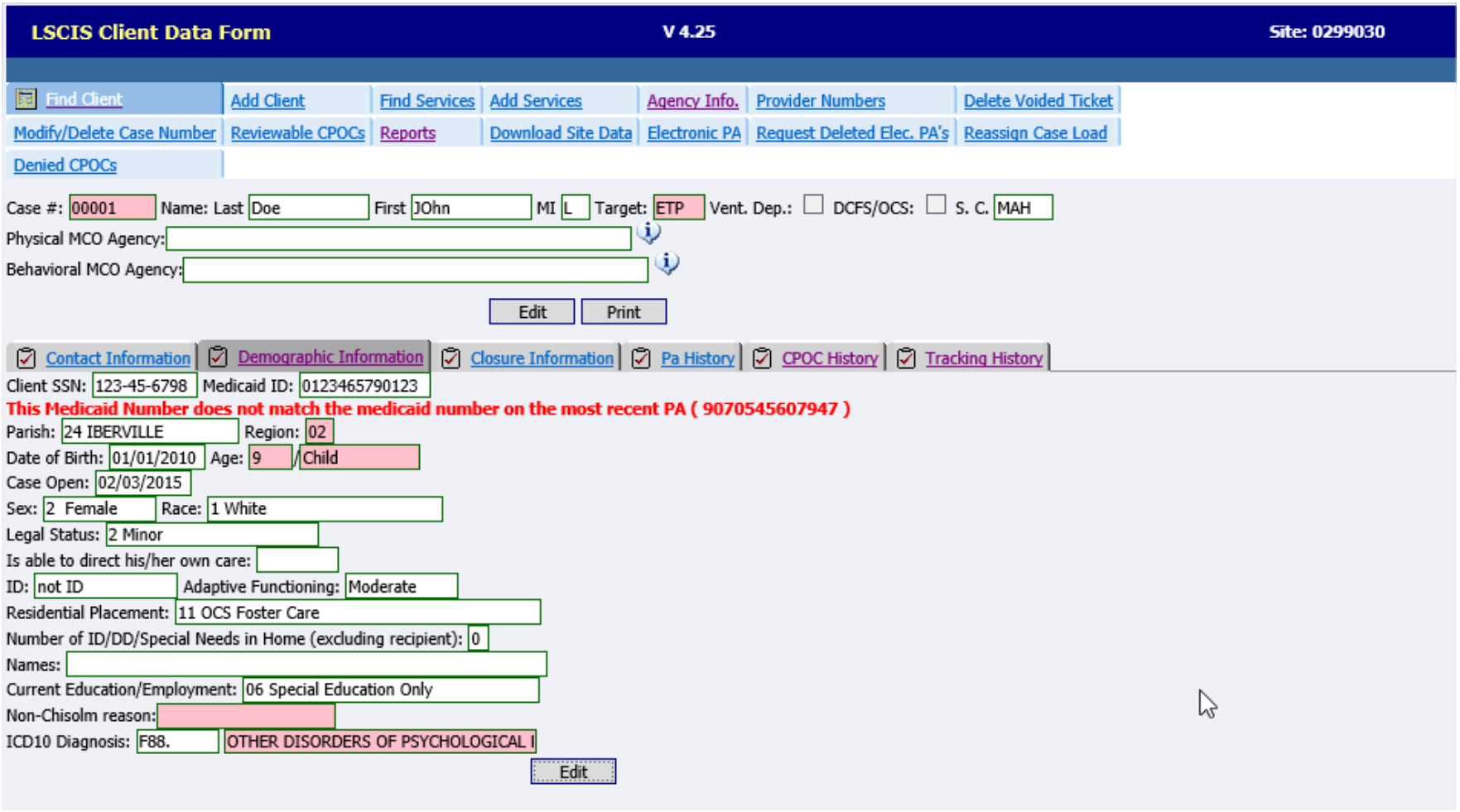
CPOC Section 1 – Contact Information / Demographic Information

This initial portion of the CPOC is self-explanatory and requires the SC to develop current contact information on the individual, including name, mailing and physical address, good contact numbers, SSN, Medicaid ID, ICD-10, etc. Nothing should be left blank.

The relationship of the legal guardian must be placed beside their name on the contact page.

If the individual is a competent major document if they can direct their own care.

LSCIS CPOC Section 1 – Contact Information / Demographic Information



CPOC Section 2 – Medical / Social / Family History

Interview those who know the beneficiary best.

Provide information about the past and current situations in the beneficiary's life and about their family. Information included is relevant to the beneficiary's life today and provides a means of sharing social/family history.

If any information is unknown, document that it is unknown.

CPOC Section 2 – Medical / Social / Family History

If there is only sketchy information available in any health status area, remember the beneficiary is eligible for screenings, which can help to determine his/her health needs. It is the Support Coordinator's responsibility to help the beneficiary access those screening services.

In addition, it is important to remember that psychological and behavioral services are available for the beneficiary and should be offered.

Always document the offer of services and the response received (requested, declined, on hold).

CPOC Section 2 – Medical / Social / Family History

Past – Pertinent historical information.

- Prenatal health and birth
- Nature and cause of disability
- Age of diagnosis and made by whom
- Any early intervention services received
- Any placement history outside of current placement
- Past medical history, surgeries, hospitalizations
- Events that lead to the request for services at this time. If there are no services to coordinate, is family aware SC is optional and declining will not affect their eligibility to receive Medicaid services or their placement on the DD RFSR?

CPOC Section 2 – Medical / Social / Family History

Present - Describe current living situation and natural supports.

- Names and ages of all household members
- Family situation and social support network (Must address both parents and if they provide any natural or financial support)
- Relevant social, environmental and health factors that impact the beneficiary
- Access to community / transportation
- Source of household income
- Desires and requests
- Education needs

CPOC Section 2 – Medical / Social / Family History

Medical Diagnoses - A brief narrative description of the person's health history, current medical condition, including medical diagnoses, hospitalizations and continuing health concerns and medical needs should be included.

- List all diagnoses and what *current* formal documentation you have to support their qualifying diagnosis or diagnoses.
- If any diagnosis is "parent states" and you don't have documentation to back it up address what you're doing to obtain documentation. If no documentation exists address if they want a referral for an evaluation.
- List all medical specialists - name, specialty, how often they see them, and last visit/next visit identifying if they overdue for a visit. Example:

  Dr. Brown/PCP, Annually, Last 7/2022, Overdue - SC offered scheduling assistance. Mom declined and will schedule. Aware recommended annually.

  Dr. Smith/Dentist, Bi-Annually, Last 9/2023, Next TBD.

  Dr. Kennedy/Psychiatrist, Annually, Last 10/2022, Next 11/8/23.

  Dr. Clark/ENT, PRN, Last Summer 2021.

- List all medications and what they are prescribed for.

CPOC Section 2 – Medical / Social / Family History

Medical Diagnoses

- Vison
- Hearing
- Communication
- Mobility
- Toileting needs
- Dietary needs
- Do they need assistance with their ADLs? If so was PCS offered? If PCS is requested/received, what ADLs do they need PCS to assist with?
- What therapies do they receive at school and were community therapies offered?
- What assistive devices or DMEs do they have or need?
- Any special procedures or medical equipment like g-tube, trach, catheter? How often is the special procedure administered? Skilled nursing or EHH?

CPOC Section 2 – Medical / Social / Family History

Psychiatric/Behavioral - A narrative description of the person's psychiatric status, diagnoses and significant behavior concerns

- Address behaviors at both home and school.
- Describe the behavior – what exactly does it look like?
- How often do behaviors occur? Be specific (throughout the day and an episode can last 15-30 minutes, daily, a few time per month, etc.).
- Any significant behavioral incidents? Document month and year and what exactly occurred.

CPOC Section 2 – Medical / Social / Family History

Psychiatric/Behavioral

- Any known triggers?
- What strategies are used? How are the behaviors managed?
- What behavior services were offered and which are received/requested?

CPOC Section 2 – Medical / Social / Family History

Psychiatric/Behavioral

- If the beneficiary has an Autism (or related) diagnosis or has even been labeled, even informally, as having Autism (or related diagnosis), please make sure you are either:
  - connecting the class member with Applied Behavioral Analysis (ABA),
  - referring for testing to assess the need, or
  - documenting that the family declined these services. If declined, please revisit ABA with the family at least annually.
- As you know, autism services can be most effective when delivered as early as possible in a child's life. Services usually should begin at ages 2 to 6. The needed early connection is thwarted if support coordinators fail to identify ABA as a possible therapy and arrange it unless declined.

CPOC Section 2 – Medical / Social / Family History

Evaluation/Documentation

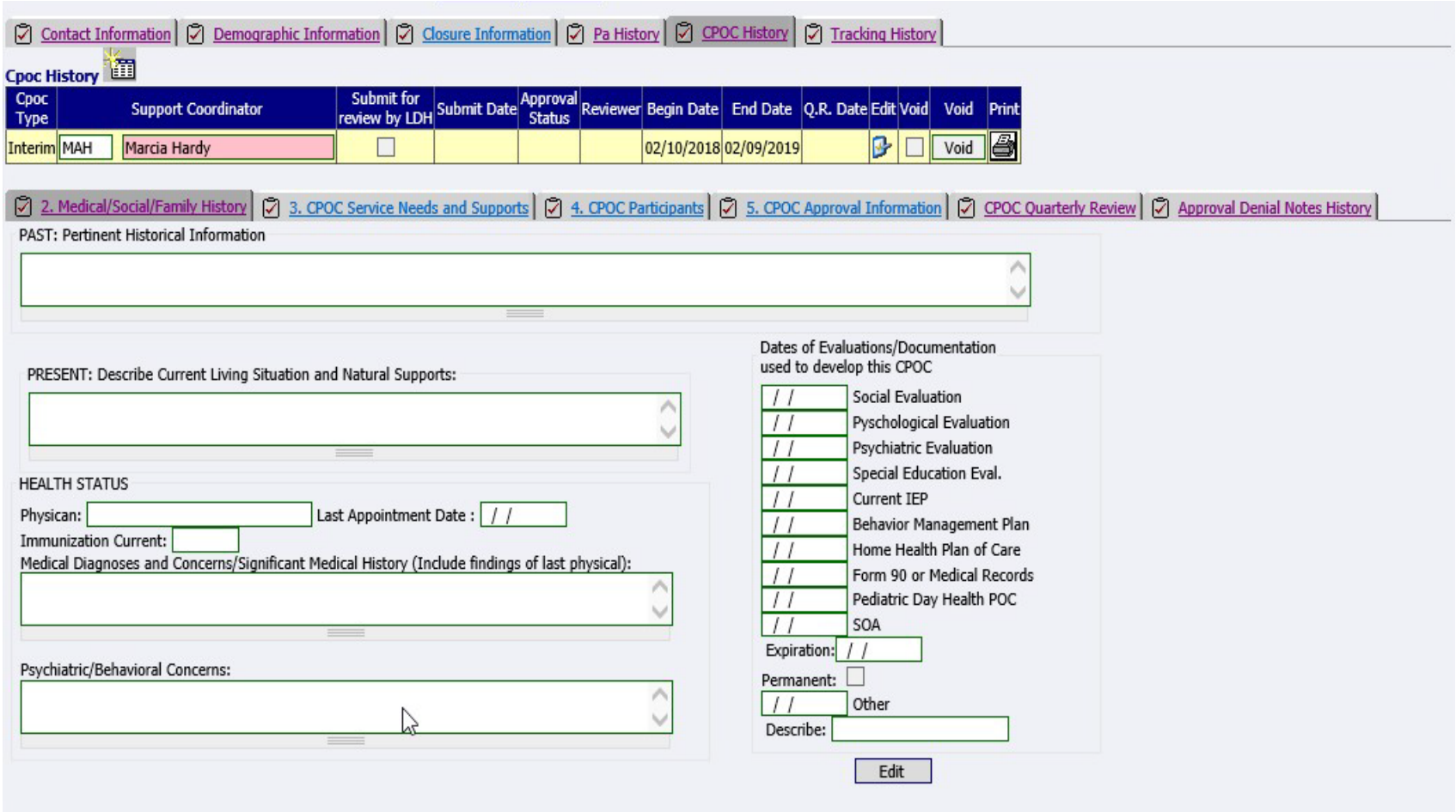
- Dates of formal information documents used in the development of the CPOC are to be listed.
- At least one current formal information document is required in the development of an annual CPOC.
- Current means that the formal information document was less than a year old at the time of the plan of care meeting.

CPOC Section 2 – Medical / Social / Family History

Evaluation/Documentation

- Must have the following documents on file:
  - A current formal information document that was less than a year old at time of the CPOC meeting.
  - Current IEP if receiving Special Education
  - Current EHH Plan of Care if receiving Extended Home Health
  - Current PDHC Plan of Care if receiving Pediatric Day Healthcare
  - Current SOA from OCDD, or must have redetermination as a service need if it's expired/expiring this CPOC year (unless receiving Special Needs SC).
    - Make sure to enter either the expiration date or check the Permanent box.

LSCIS CPOC Section 2 – Medical / Social / Family History



CPOC Section 3 – CPOC Service Needs and Supports

This section of the CPOC identifies service needs including:

- the service strategy and a description,
- how the need was determined,
- if the individual requests to receive the identified need and any reasons why not,
- the primary goal,
- who is providing the support,
- if the service requires PA tracking and reason for not tracking any Medicaid services,
- and the amount of service approved.

CPOC Section 3 – CPOC Service Needs and Supports

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the beneficiary receives the services they need to achieve or maintain their personal outcomes.

When a service is requested, the Support Coordinator should provide the individual with the medical information forms (EPSDT-PCS Form 90, CMS 485, etc.) that are required for the specific service.

The Support Coordinator should assist with scheduling the doctor appointment, transportation, etc. as needed. The health care system can be difficult to navigate and extra support with scheduling appointments may assist with children getting access to the care they need.

If it is not a Medicaid service, the SC is to assist in locating resources to provide the service need.

CPOC Section 3 – CPOC Service Needs and Supports

Identify all services the individual is currently receiving and those services that are requested, both Medicaid and non-Medicaid, clearly identifying each service and the amounts approved.

List every service need separately (i.e. school ST, community ST).

Make sure to select the appropriate service from the Service Strategy picklist.

The description box should clarify the service need that is requested. Do not list the provider's name or use terms like requested as this may change over time.

CPOC Section 3 – CPOC Service Needs and Supports

Service Strategy Picklist

- **Personal Care Services**
- **Home Health Services** – Extended Home Health, intermittent nursing, in-home ST/OT/PT
- **Medical Equipment and Supplies** - one time DMEs like wheelchairs, hospital beds or weighted blankets and ongoing DMEs like formula, trach supplies, or g-tube supplies.
- **OT, Physical Therapy, Speech Therapy** – community therapies
- **Specialized Behavioral Health** - psychiatrist, behavioral medications, counseling, CPST, etc.
- **Dental Services**
- **Eyeglasses** – eyeglasses or contact lenses
- **Transportation** – NEMT or gas reimbursement program
- **Diapers**
- **School** – Therapies (OT, PT, ST), Assistive Technology (AT), Social Worker, Nursing
- **Vocational**
- **Employment**
- **Transition** (if the beneficiary will be twenty and half years old that CPOC year)
- **Pediatric Day Health Care**
- **Applied Behavioral Analysis**
- **Other**
- **Home Modifications**
- **Community Services**
- **Redetermination** (if the SOA expires that CPOC year)
- **OCDD Services** – family flexible fund, family support, respite
- **CSoC** - Wraparound, Peer Support, Parent Support, Independent Living Skill-Building Services, Short-term Respite
- **Evaluation** – any needed evaluations (psychological, CDE, etc.)
- **EPSDT Screening Exam**
- **Hearing Aids**
- **Hospice Services**
- **Physician/Professional** – needed referrals for doctors, anyone they are overdue for a visit with.

CPOC Section 3 – CPOC Service Needs and Supports

Select how the need was determined from the picklist.

Use the checkbox to indicate if the service is requested

- If a service need is not being requested now, you have three options to explain why:
  - **Carried Over – Resolved:** The service need is no longer an identified need. Will fall off the CPOC after CPOC approval.
  - **Family Does Not Want:** The need for the service has been identified but the individual declines the service.
  - **Other – Explain Next Page:** The need for the service has been identified but it is placed on hold until a later time. The individual will request the service need in the future.
- Always explain your reason in Section 4 – Additional Information.

CPOC Section 3 – CPOC Service Needs and Supports

Select the primary goal from the picklist.

Use the checkbox to indicate if the service is currently received.

Check the appropriate box of who will be providing/funding the service need – Medicaid, School, Community, Family (private insurance or out of pocket), or OCDD.

“Requires PA tracked by SC” must be checked for all requested Medicaid services that require a Prior Authorization, unless both a valid reason for not tracking is selected and how the SC will ensure the service is received is documented in the Additional Information section.

Indicate the amount approved as applicable.

Assure and document at the time of the CPOC meeting the individual understands that services and goals may be added whenever a request is made, if they chose not to access a service when the need is first identified.

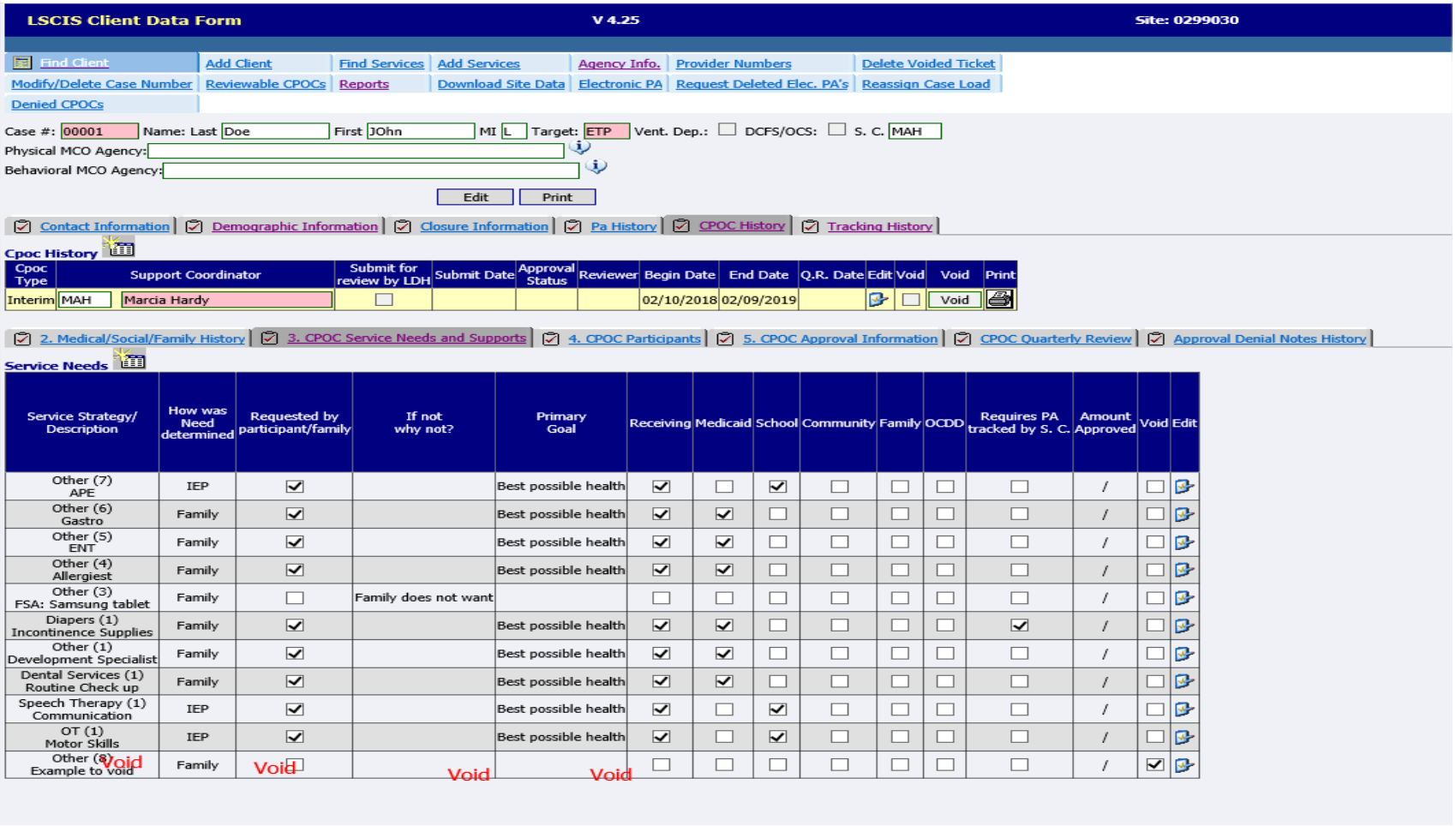
CPOC Section 3 – CPOC Service Needs and Supports

"Medicaid" and "Requires PA Tracked by SC" must be checked in order to generate the required PA Tracking log. Valid Reasons for Not Tracking Medicaid services:

1. A PA is not needed to receive the Medicaid service.
2. The PA is issued monthly.
3. The EHH nurse is the person ordering and tracking medical supplies.
4. The beneficiary has been placed on a waitlist. (Must complete waitlist placement steps as identified on Handbook – Waitlist Placement section.)
5. The beneficiary is receiving the service without a PA (Refer to *Appendix BB-4* – Modification of Rehab Services PA Tracking/PAL Referral; must restart PA tracking when PA is received. If no PA is needed use reason 1.)
6. The beneficiary is in CSoC and the service is being authorized by Magellan.

Refer to Handbook – PA Tracking FAQ section for more detailed information.

LSCIS CPOC Section 3 – CPOC Service Needs and Supports



CPOC Section 4 – Additional Information / CPOC Participants

CPOC Participants - The beneficiary and the legal guardian must be present for the CPOC meeting.

CPOC Signature Page (paper form) –

- Planning Participants - As the Support Coordinator, it is your responsibility to have **everyone sign the printed LSCIS CPOC signature page** indicating their participation in the meeting. Again, if a person is present at the meeting they should SIGN in the Planning Participant's box.
- The beneficiary and/or legal guardian/authorized representative must sign and date the completed CPOC.
- The support coordinator conducting the meeting must sign the CPOC.
- The SC supervisor must sign indicating they completed their review prior to submitting an approvable CPOC to BHSF/Statistical Resources, Inc. (SRI).

CPOC Section 4 – Additional Information / CPOC Participants

CPOC Participants (LSCIS) –

- The individuals listed as Planning Participants in LSCIS must match the Planning Participants on your CPOC signature page (paper form).
- The signature date of the Participants/Guardian's signature on the CPOC Signature Page (paper form) is to be entered into LSCIS.
- The Support Coordinator must sign and date the CPOC and have their supervisor review the plan.
- Ready for Supervisor Review - SC checks this box to submit to Supervisor for review and submittal to BHSF/SRI.

CPOC Section 4 – Additional Information / CPOC Participants

Additional Information

- An Additional Information section is provided to address information regarding service needs and supports. The names of all service providers and any additional strategy information are to be placed in this section.
- If on a waitlist and PA tracking is not checked:
  - document that you offered alternative providers that may not have a waitlist and response received,
  - document that the waitlist placement was confirmed with the provider,
  - document that the SC notified the PAL,
  - document how you will ensure they move up the waitlist (must follow up with provider at least monthly).
- If family is checked instead of Medicaid for services typically covered by Medicaid explain why (i.e. covered by private insurance, family chose to purchase, etc.).
- If any needs are marked as carried over – resolved, family does not want, or other – explain next page, explain why.

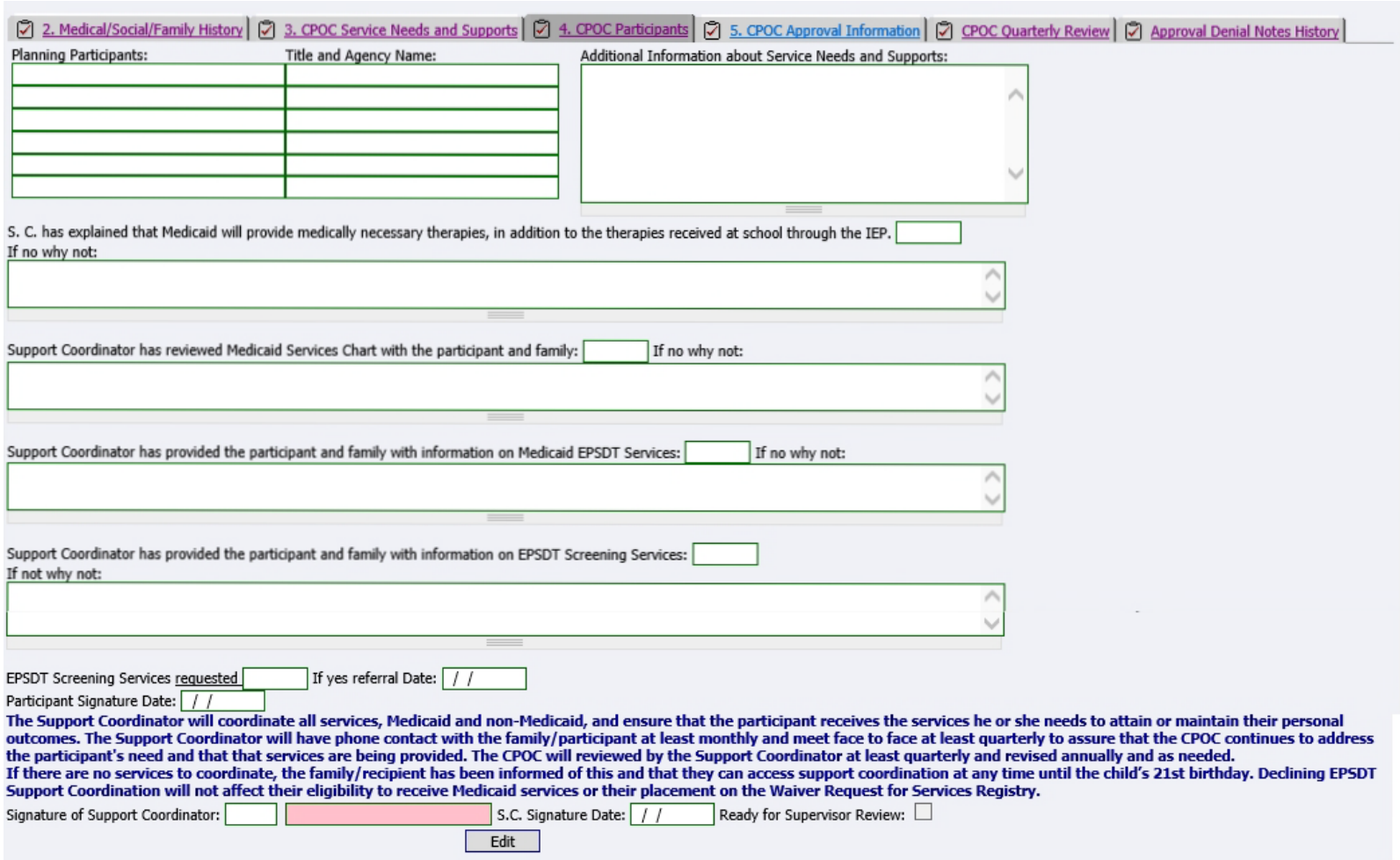
CPOC Section 4 – Additional Information / CPOC Participants

Document that the following occurred:

- Explanation and review of Medicaid Services Chart, Services Available to Medicaid Eligible Children Under 21, and Information on EPSDT Screening services.

Identify how often the goals and support strategies will be reviewed. The CPOC must be reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

LSCIS CPOC Section 4 – Additional Information / CPOC Participants



CPOC Section 5 – CPOC Approval Information

- Signature of SC Supervisor - denotes that they approve and agree with the content of the CPOC being submitted. The Formal Information documents listed under evaluations/documentation used to develop the CPOC, the prior CPOC, Service Logs, and Quarterly Reviews must be reviewed by the Supervisor for identified needs and the status of requested services. The entire CPOC must be reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

- Submit for review by LDH - SC Supervisor checks this box to submit to SRI for review and approval. The CPOC will not transmit unless all required fields are completed.

- See Service Tickets - This button allows you to review all Service Logs from the prior CPOC year which is required as part of the CPOC approval process.

CPOC Section 5 – CPOC Approval Information

Approval/Denial Information - BHSF/SRI will review the CPOC to assure that all components of the plan have been identified. If any deficiencies exist, SRI will list them in the Approval/Denial Notes box and return the CPOC for resubmittal. Review the Approval/Denial Note box on all returned CPOCs. An approved CPOC may have a note to address something on an interim CPOC or information regarding the PA.

An **approvable** initial CPOC must be completed and sent to BHSF/SRI within 35 calendar days of the date of referral to the Support Coordination agency. If the approvable CPOC is submitted timely the PA will begin on the CPOC Participant Signature Date. If the CPOC is late the PA will begin on the approvable CPOC submit date. (Refer to the Aging Report in LSCIS.)

The annual CPOC meeting should not be held more than 90 calendar days prior to the expiration of the current CPOC. The **approvable** annual CPOC must be completed and submitted to SRI within 35 calendar days of the CPOC expiration date. If the CPOC is submitted late you will not meet the flat rate billing requirement of a Timely CPOC. (Refer to the CPOC Updates report in LSCIS.)

CPOC Section 5 – CPOC Approval Information

Documents to Submit to SRI (via fax 225.767.0502 or e-mail ksalling@statres.com)

- *Appendix Z-1* and the required documents for all Initial CPOCs
- *Appendix Z-1* and the required documents for all beneficiary's labeled "Special Needs" in LSCIS. Must include current formal information documents to support that they continue to qualify for Special Needs EPSDT Support Coordination.
- *Appendix Z-2* and the required documents if the Annual CPOC is randomly selected for monitoring when it is submitted to BHSF/SRI for approval.

Annual CPOCs that are not Special Needs and are not selected for monitoring are to have the documents placed in the case record and submitted to BHSF/SRI immediately upon request.

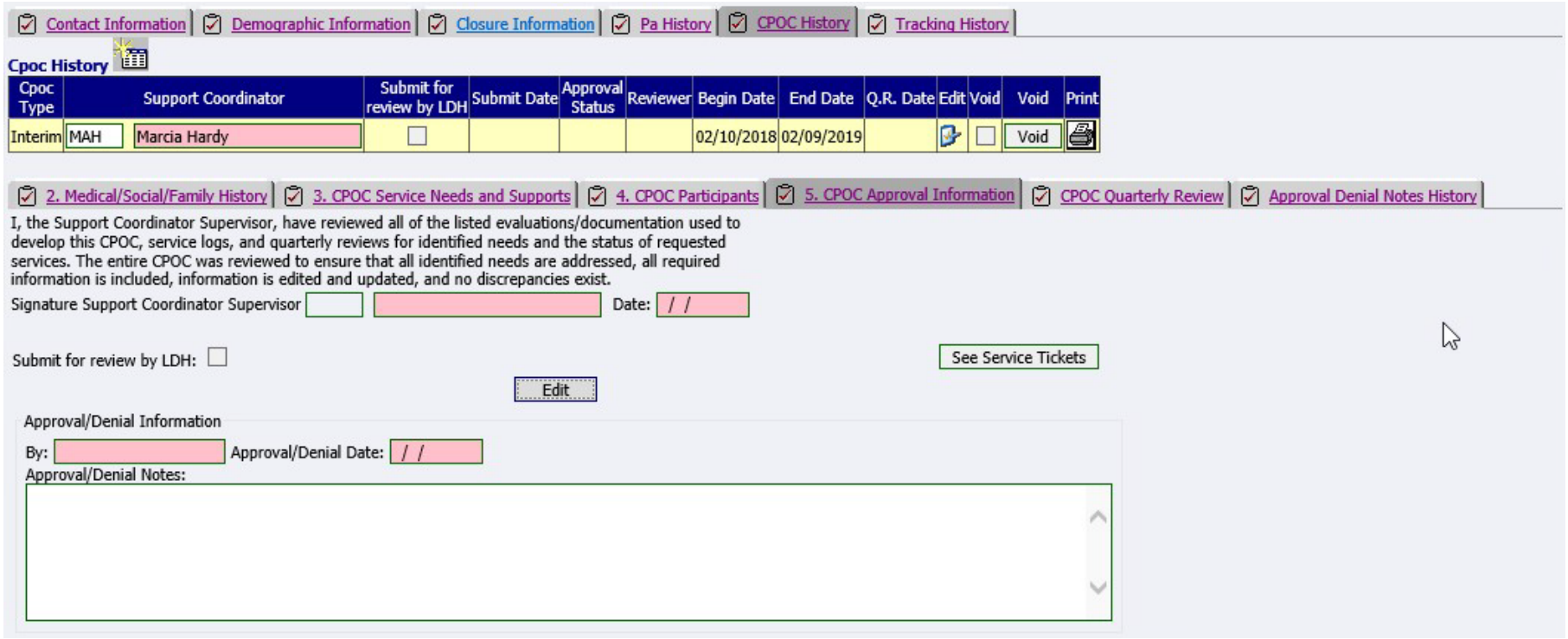
CPOC Section 5 – CPOC Approval Information

The Support Coordinator is responsible for requesting and coordinating all services identified in the CPOC immediately upon completion of the CPOC and prior to approval from SRI.

Since approval of Medicaid state plan services is through the prior authorization unit, there is no reason for the Support Coordinator to await BHSF/SRI approval of the CPOC before making referrals for necessary services.

Again, the CPOC does not control the services. The CPOC approval process only controls the payment to Support Coordination Agencies.

LSCIS CPOC Section 5 – CPOC Approval Information



CPOC Section 6 – Typical Weekly Schedule (Paper Form)

The typical weekly schedule is a tool that the Support Coordinator uses to assure that services are delivered at appropriate days and times and do not overlap, unless this is medically necessary.

Include all approved services the beneficiary is currently receiving.

Include new services the beneficiary is requesting.

Show when the beneficiary is in school, at home or participating in other activities.

CPOC Section 6 – Typical Weekly Schedule (Paper Form)

The schedule can be forwarded to in-home providers and prospective providers to support and clarify prior authorization requests.

If prior authorization is denied and not appealed, or if for any other reason the planned services are not delivered, the schedule should be amended to reflect services actually put in place. If the beneficiary wishes to change any of the times for established services, the Support Coordinator shall give the revised schedule to all appropriate providers informing them of the time changes to facilitate the change.

This document is kept in the case record.

Part 4

COORDINATION OF SERVICES

Referral and Related Activities

Support Coordination includes the following assistance:

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

Coordination of Services

Once the needed Medicaid services (personal care, medical equipment and supplies, home health, etc.) have been identified in the CPOC, it is the Support Coordinator's responsibility to coordinate the service. **Again, do not wait for BHSF/SRI to approve the CPOC!**

The Support Coordinator should provide as much assistance as possible to the family to identify and obtain other non-Medicaid services (home modifications, respite, financial assistance, etc.) that are identified in the plan.

The CPOC is considered a holistic plan. Therefore, **the Support Coordinator is responsible for coordinating all identified service needs**, including paid and un-paid supports as well as non-Medicaid Services.

The Support Coordinator must be knowledgeable of potential community resources, including formal resources such as Supplemental Nutrition Assistance Program, SSI, and housing.

Coordination of Services

Some Medicaid services such as Personal Care Services, Home Health, and Durable Medical Equipment (DME) require prior authorization before they can be provided.

Typically, a Medicaid-enrolled provider of the service develops and submits an application for the service to the prior authorization unit.

Requests may be denied if the item or service requested is not medically necessary, or if it is outside the scope of services covered by Medicaid. A notice of denial will be sent to the beneficiary, the provider, and you, the Support Coordinator. The beneficiary then has the right to appeal the denial.

PRIOR AUTHORIZATION LIAISON (PAL)

Prior Authorization Liaison

The PAL unit was established to facilitate the PA approval process for Medicaid beneficiaries under age 21 who are on the Developmental Disabilities Request for Services Registry (Chisholm class members).

The Chisholm v. LDH lawsuit settlement stipulates that the support coordinator is notified of requests, status, and any delays to the PA approval process.

The PAL will maintain a tracking system to ensure support coordinators remain aware of the status of PA requests, submission, decision dates and reconsiderations.

Prior Authorization Liaison

The PAL will assist with problems on each prior authorization request so that a decision is rendered as to medical necessity.

PA requests are given to the PAL when the request cannot be approved due to:

- Lack of documentation, or
- Technical errors:
  - Overlapping dates of service
  - Missing or incorrect diagnosis codes
  - Incorrect procedure codes
  - Prescription not signed by the doctor

Prior Authorization Liaison

The PAL will attempt to resolve the problem.

Within 24 hours of the PAL receiving the request, the PAL makes the initial contact by phone or fax with the provider, beneficiary, and support coordinator.

Prior Authorization Liaison

If the issue is not resolved after 10 days of initial contact with the provider, a Notice of Insufficient Documentation is sent to the provider, beneficiary and support coordinator advising them of the specific documentation needed.

The beneficiary has 30 calendar days to either supply the needed documentation, or notify the PAL with the appointment date that has been made with the health professional to obtain it.

Prior Authorization Liaison

Support Coordinator Role

- Communicate promptly with the PAL to facilitate requests for information.
- Communicate with the individual and provider and provide assistance in assembling documentary support on prior authorization requests.
- Follow up so that a PA decision is received, instead of having the service denied due to a lack of information.
- Track status of requests:
  - Advise PAL of providers not actively developing requests.
  - Inform beneficiaries of their right to choose another provider.
  - Assist beneficiaries in locating another provider.

Prior Authorization Liaison

Support Coordinator Role (continued)

- If a “Notice of Insufficient Documentation” is received, assist the beneficiary in obtaining documentation. If you are not sure enough additional information is available, help the beneficiary schedule an appointment with a health professional and return the second page of the Notice filled in with the date of the appointment to the PAL.
- **When a SC closes a PA tracking log that had a PAL Referral sent to LDH, the SC should notify LDH of the closure date and reason.** This allows LDH staff to focus on the active PAL Referrals. Send Referral to PAL - Check box 8, explain and attach documentation.

Prior Authorization Liaison

- **LDH PAL**

  Danielle Boykin
  jerri.boykin@la.gov
  (225) 342-7873
  Fax: (225) 389-2749 or
  1-877-747-0997

- **Gainwell Technologies PAL**

  Monica Anderson
  225-216-3224
  Fax: 225-216-6478
  Gainwell Technologies
  Prior Authorization Liaison
  P. O. Box 14919
  Baton Rouge, LA 70898-4919

*You only need to contact the Gainwell Technologies PAL to return call.

Prior Authorization Liaison MCOs

For a list of MCO Prior Authorization Liaison contacts at each MCO, refer to *Appendix X-2 – MCO Contacts for EPSDT SCA.*

Prior Authorization Liaison

Refer to *Appendix BB* –

Medicaid Prior Authorization Packet.

Refer to *Appendix BB-3* for

a sample of the PAL notices.

Prior Authorization Liaison

To summarize the PAL and Support Coordinator's roles:

- If additional information is needed to process the request, the PAL will contact the provider, beneficiary, and support coordinator within 24 hours.
- The support coordinator is to assist in obtaining the additional information. This will not supplant the responsibilities of the provider.
- The support coordinator will receive a copy of all notices (i.e. approved, denied, reduction in services and request for additional information) regarding the requested service.

OVERVIEW OF COORDINATION OF SERVICES

Coordination of PAed Services

The Support Coordinator plays a role in the prior authorization process by:

- assisting beneficiaries in identifying services they will request;
- providing the specific medical information forms, that the physician must complete, for the requested services (Refer to *Appendix BB-1*, LaMedicaid.com or the LDH website) and assisting with the scheduling of physician appointments, transportation, etc., to have the forms required for a PA request completed;
- locating providers willing to submit the request;
- assisting, if necessary, in assembling documentation needed to support the PA request;
- making sure providers submit requests timely and tracking the status of the request;
- communicating with the PAL, notifying them of any upcoming doctor's appointment, and helping to supply any missing documentation of medical need;
- follow through with requests for services until the PA is either approved or denied based on medical necessity; and
- assisting the beneficiary with making a decision about whether to appeal any denials of services, and assisting with the appeal if the beneficiary decides to appeal and wants assistance.

Coordination of Services

Even if a Prior Authorization is not required for the Medicaid service or there is a valid reason why the Support Coordinator does not track the PA (PA not required, PA issued monthly, etc.), the Support Coordinator is still responsible for coordinating the service.

The Support Coordinator plays a role in the process by:

- assisting beneficiaries in identifying services they will request;
- locating willing providers;
- assisting, if necessary, in assembling documentation needed to support the request; and
- following through with requests for services.

LOCATING PROVIDERS

Coordination of Services

At the beginning of every month, verify Medicaid eligibility and establish enrollment type.

Once the Support Coordinator determines who covers the beneficiary's physical health, behavioral health and transportation services they can determine who will administer/cover specific Medicaid services for the beneficiary.

For Medicaid FFS: prior authorization requests are acted on by the Prior Authorization Unit of Gainwell Technologies, a company that contracts with the Louisiana Department of Health to perform this function.

For MCO: prior authorization is handled by the individual Managed Care Organization (MCO).

Enrollment Types

B-linkage: Refers to enrollment in an MCO for specialized behavioral health services (SBHS) and non-emergency medical transportation (NEMT), including non-emergency ambulance transportation (NEAT).

P-linkage: Refers to enrollment in an MCO for physical health, behavioral health, and transportation services.

Physical Health Services

Physical Health Services will either be accessed:

- through Gainwell Technologies, if the beneficiary is a B-linkage or
- through the beneficiary's Managed Care Organization if the beneficiary is a P-linkage.

Locating Medicaid FFS Providers for Physical Health Services

Specialty Care Resource Line - 1-877-455-9955

Support Coordinators can call the Specialty Care Resource Line to find medical providers of various types and specialties for their beneficiaries and to help identify needed sources for referrals that may otherwise be difficult to find.

The Specialty Care Resource Line is supported by an **automated resource directory** of all Medicaid-enrolled providers of medical services, including physicians, dentists, mental health clinics, and many other health care professionals. The database is updated regularly.

Locating FFS Providers for Physical Health Services

A list of available providers is available through the Medicaid website at ldh.la.gov/medicaid.

Click Locate a Provider, select the service need you're looking for under Provider Groups & Provider Specialties, and select the region or parish where the beneficiary lives.

- Note: PCS-EPSDT is a listed Provider Specialty under the Personal Care Services Provider Group.

The direct website address to find a provider is: https://www.lamedicaid.com/apps/provider_demographics/provider_map.aspx

Locating MCO Providers for Physical Health Services

Support Coordinators should assist with locating a provider contracted with their MCO.

Resources for locating providers include:

1. Online Provider Directory at www.myplan.healthy.la.gov.
   - Select Choose > Find a Medical or Dental Provider.
   - Search by Medical Providers.
   - Search by Location (zip, city, parish)
   - You can search for specific providers to see which plans they are contracted with or search for providers by Specialty (i.e. Neurology, Personal Care Attendant, etc.).
     - Note: You can search for PCS by selecting Personal Care Attendant from the Provider Specialty field.
2. Call the Member Services Line at each MCO to locate a provider in their network. Refer to *Appendix X-2 – MCO Contacts for EPSDT SCA.*
3. Access the MCO's website to identify contracted providers. Refer to *Appendix X-2 – MCO Contacts for EPSDT SCA.*

Behavioral Health Services

Behavioral Health Services will either be accessed:

- through the beneficiary's individual Managed Care Organization for B-linkages and P-linkages or
- through Magellan if the beneficiary is enrolled in the Coordinated System of Care (CSoC) waiver.

Locating Behavioral Health Providers - MCO

Support Coordinators should assist with locating a provider contracted with their MCO. Resources for locating providers include:

1. Online Provider Directory at www.myplan.healthy.la.gov.
   - Select Choose > Find a Medical or Dental Provider.
   - Search by Behavioral Health Providers.
   - Search by Location (zip, city, parish)
   - You can search for specific providers to see which plans they are contracted with or search for providers by Specialty (i.e. Behavioral Health Rehabilitation Services, Crisis Stabilization, etc.).
     - Note: You can search for a BH therapist by selecting Outpatient Therapy.

2. Call the Member Services Line at each MCO to locate a provider in their network. Refer to *Appendix X-2 – MCO Contacts for EPSDT SCA*.

3. Access the MCO's website to identify contracted providers. Refer to *Appendix X-2 – MCO Contacts for EPSDT SCA*.

Locating Behavioral Health Providers – Evidence Based Programs

To locate EBP providers near you, you can:

- use the interactive map found here: https://laevidencetopractice.com/interactivemap/
- contact the beneficiary's MCO and ask for help from a Behavioral Health Care Manager or contact Magellan for youth enrolled in CSoC to find an in-network EBP provider.

Locating Behavioral Health Providers - Magellan

For youth enrolled in the Coordinated System of Care (CSoC) waiver program, specialized behavioral health services are managed by the CSoC Contractor, Magellan:

- Specialized behavioral health services can be accessed by contacting Magellan at 1-800-424-4489/TTY 1-800-424-4416.
- The SC should also consult the Wraparound Agency to have the provider and service added to the youth's plan of care and be included in the Child and Family Team (CFT).

Note: Therapeutic Group Home (TGH), Psychiatric Residential Treatment Facilities (PRTF) and Residential Substance Use will be prior authorized by their Managed Care Organization.

Transportation Services

The beneficiary's Managed Care Organization will cover medical transportation services including NEMT/NEAT. No prior authorization is required.

The transportation phone numbers for each MCO can be found on *Appendix C – MCO Service and Equipment Flyer.* For NEAT services use the information on *Table 4: Call Centers for NEAT Services* found in the Handbook – Medical Transportation section.

Dental Services

Contact the beneficiary's dental plan to obtain a list of available providers:

- DentaQuest at 1-800-685-0143 or visit dentaquest.com
- MCNA Dental at 1-855-702-6262 or visit mcnala.net.

PRIOR AUTHORIZATION TRACKING

Prior Authorization Tracking

PA Tracking begins with the request for the service, not when the choice of provider or prescription is received or when the CPOC is approved.

When the beneficiary requests a Medicaid service that requires a prior authorization:

1. Add the service need to the CPOC in LSCIS. Select the appropriate **Service Strategy** and enter a **Description**.
2. Check **Requested by participant/family** box.
3. Check the **Medicaid** box.
4. Check the **Requires PA tracked by SC** box or select **Reason for Not Tracking**.
5. If **Medicaid** and **Requires PA tracked by SC** are checked, follow the prompts on the Tracking Required Action Report beginning with opening an EPSDT Prior Authorization Tracking Log. To open an EPSDT PA Tracking Log, go to the beneficiary's Tracking History in LSCIS and click the add new Tracking Log button.

Determining if a service need requires a prior authorization

For FFS: Refer to the Medicaid Services Chart.

For MCO: The MCOs have PA look-up tools that can be used to determine if a particular service requires a Prior Authorization or not. Refer to these websites:

- Aetna Better Health
- AmeriHealth Caritas
- Healthy Blue
- Humana Healthy Horizons in Louisiana
- Louisiana Healthcare Connections
- UnitedHealthcare Community Plan

For ABA when beneficiary has Medicaid as secondary, refer to the ABA Secondary Prior Authorization Requirements

For Medicaid services that do not require a Prior Authorization, check requested, check Medicaid and then select reason **01 PA not required** from the Reason for Not Tracking picklist.

Prior Authorization Tracking Log

The electronic EPSDT Prior Authorization Tracking Log is an important tool for Support Coordinators for several reasons. It will:

- help you assure the beneficiary is receiving the services requested;
- serve as a reminder to contact the provider if you have not received a copy of the Request for Prior Authorization form;
- serve as a reminder to make required PAL referrals;
- allow you to know at a glance when, and if, services were/were not approved;
- serve as a reminder of when the notice should be sent to the provider to renew services;
- allow you to document information about the PA decision notice;
- allow you to document that you offered/provided appeal assistance to the beneficiary and provided the Appeals Brochure.

Prior Authorization Tracking Log

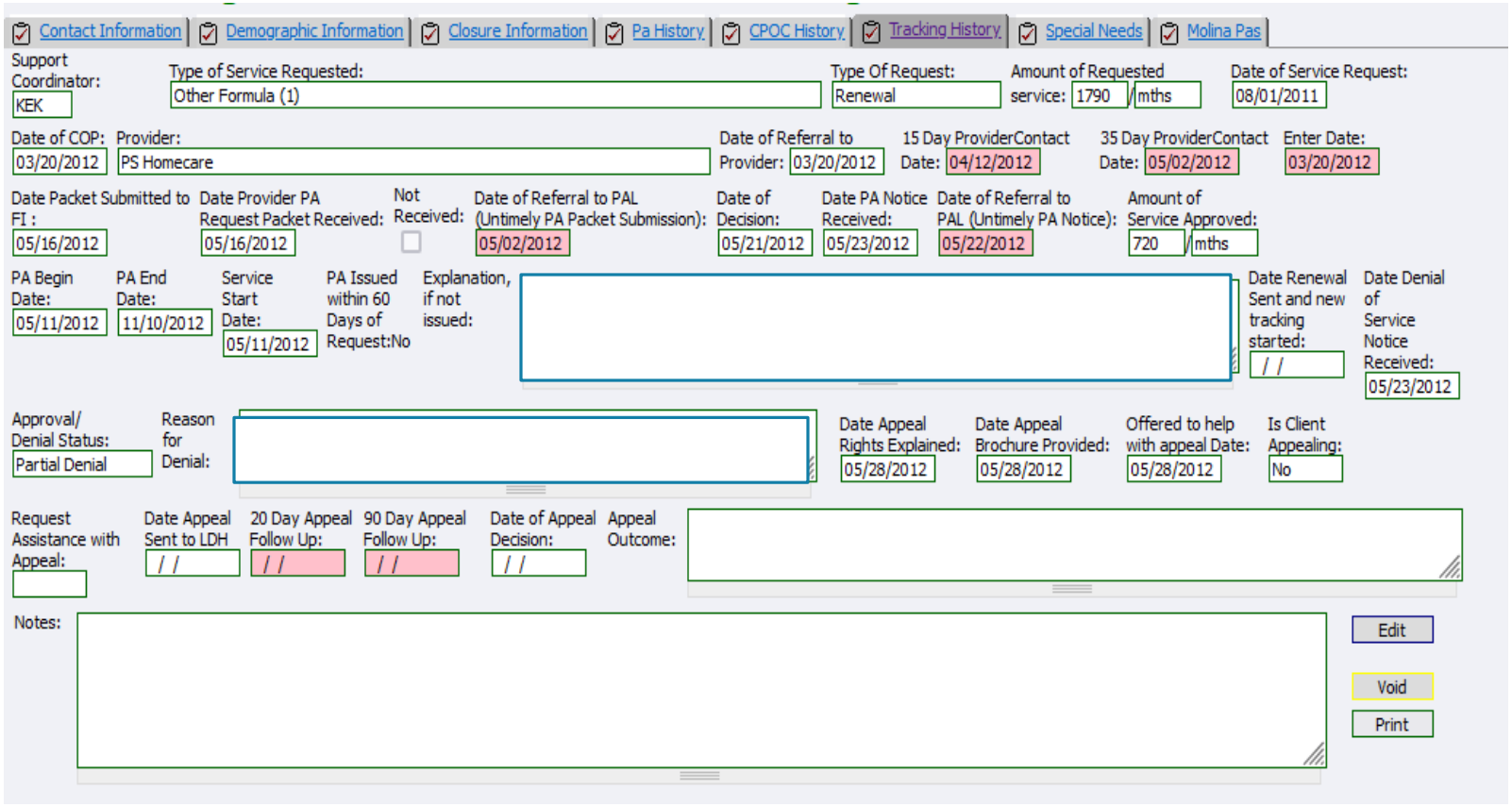
The electronic EPSDT Prior Authorization Tracking Log will be used to document the nature and specific amount of each service being sought, provider and PAL referrals, provider contacts, and information about approval, denial and appeals.

A separate EPSDT PA tracking log is completed for each service that requires prior authorization and for each PA cycle.

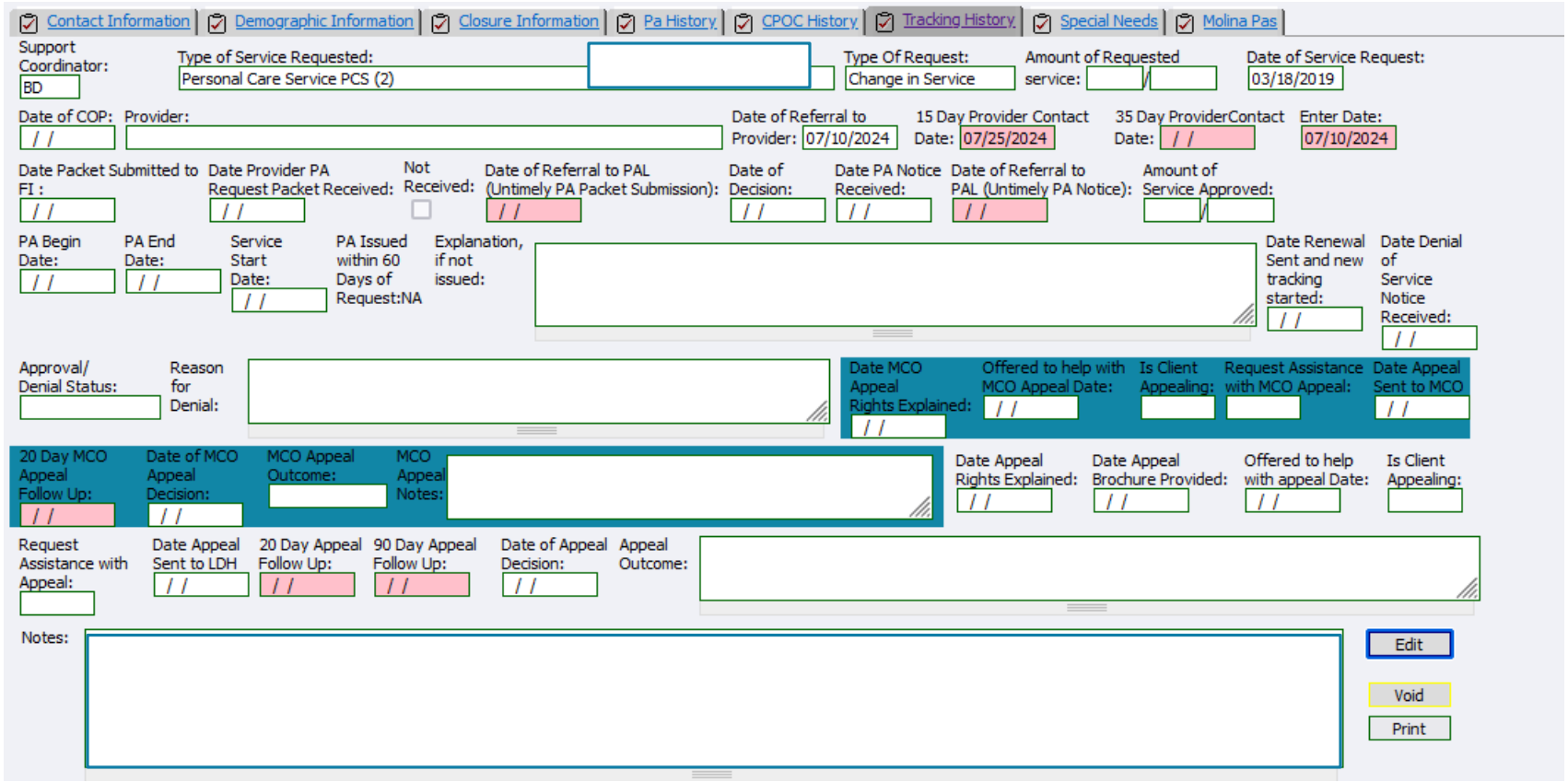
A new **Renewal** tracking log is used for each PA cycle after the reminder notice for renewals is sent to the provider. The date the reminder notice is sent is the date of referral for a new tracking log. Keep the date of service request the same as the previous tracking log. Always enter a new choice of provider date.

A new **Change in Service** tracking log is used for changes in existing services (i.e. additional hours of service requested, change in providers). Keep the date of service request the same as the previous tracking log.

LSCIS Prior Authorization Tracking Log for Medicaid FFS



LSCIS Prior Authorization Tracking Log for MCO



Obtain Required Documentation

Upon request of a Medicaid Service, the Support Coordinator must obtain required documentation to support the medical necessity of the request:

- Give the beneficiary the medical information forms that are required for the specific service. Many forms can be found in *Appendix BB-1 – PA Request Forms and Physician Forms.*
- Assist with scheduling the doctor appointment, transportation, etc., as needed.
- Assist the beneficiary and/or provider in gathering the appropriate documentation needed to support the request.

Freedom of Choice

Upon request of a Medicaid Service, the Support Coordinator must offer a freedom of choice:

- Give the individual a Choice of Providers (unless they are already satisfied with a provider).
- Assist the beneficiary in contacting prospective providers and finding out if they are willing to submit prior authorization requests.

Choice of Provider

Once the beneficiary makes a choice of provider:

- Enter the date the beneficiary chose the provider and the Provider's name into the EPSDT PA Tracking Log.
- Have the beneficiary list the provider they choose and sign *Appendix Z - Choice of Provider Form*.
- Within 3 calendar days from date of choice of provider, SC sends *Appendix V-1 - Referral to Provider*.
  - *Note:* For Initial CPOCs the Referral to Provider must be made within 3 calendar days of CPOC completion, or within 3 calendar days of the choice of provider if the date of provider selection is later than the CPOC meeting.

Choice of Provider

Provider Contacts

- **Within 15 calendar days of the Referral to Provider,** contact the provider to confirm that they are working on the request and to see if they need any assistance gathering information.
- **Within 35 calendar days of the Referral to Provider,** contact the provider and ask if the request has been submitted to the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care or if there are problems that you could assist with.

PA Packet

Once the provider submits the PA packet to the FI/MCO (Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care), enter the Date Packet Submitted to FI/MCO into the EPSDT PA Tracking Log.

If the SC receives the PA packet enter the date received into the Date Provider PA Request Packet Received box of the tracking log. If it's not received check the Not Received box on the tracking log.

If a notice of decision or a PAL notice is not received within 10 calendar days of the date the PA packet was submitted to the FI/MCO (or 25 calendar days for DME requests), contact the provider. **Continue to follow up until the PA packet is approved or denied based on medical necessity.**

Untimely PA Packet

If a Prior Authorization packet is not submitted within 35 calendar days of Referral to Provider:

- Send Appendix V-2 – Referral to PAL – check box 1.
- SC must offer beneficiary alternative providers.
- Continue to follow-up with the provider until the PA packet is submitted and remind the beneficiary that they can change providers.

Decision Notice

When you receive the notice of decision, enter the following information into the EPSDT PA Tracking Log:

- Date of Decision
- Date PA Notice Received
- Amount of Service Approved
- PA Begin Date
- PA End Date
- If PA was not issued within 60 days of request, enter the explanation.
- Approval/Denial Status

Untimely PA Notice

If a Prior Authorization decision has not been received within 60 calendar days of the date of choice of provider:

Send *Appendix V-2 - Referral to PAL* – check box 2.

Also inform the beneficiary about their right to change providers.

Appeals / Reduction in Service

If a beneficiary's service is denied or partially denied, the Support Coordinator must discuss and document the following:

- that the beneficiary was informed of appeal rights;
- that the beneficiary was given the appeals brochure;
- that the Support Coordinator offered to assist with an appeal;
- if assistance was given on the appeal:
- the coordination of documents:
- the submission of documents to the appeals office or if no documentation was available;
- the date the appeal was filed;
- if the Support Coordinator did not assist with the appeal, the reason assistance was not provided; and
- if an appeal was filed, the response to the appeal and the final decision.

Appeals / Reduction in Service

If a beneficiary's service is denied or partially denied, the Support Coordinator must discuss and document the following:

- Explain that the beneficiary can receive the services or items that have been approved, and appeal for whatever was denied. They do not need to choose between filing an appeal and receiving the approved services.
- Explain that services will be continued pending appeal if the appeal is filed within the 30 day appeal period
- The support coordinator must ask the individual if they need or want assistance with filing the appeal.
- The support coordinator must assist with an appeal if assistance is wanted by the beneficiary.

Notice of Denial – **FFS**

For FFS:

1. Within 4 calendar days from the notice of denial:

- Explain appeal rights and offer assistance
- Explain that the provider can request a reconsideration.
- Explain that services can be continued pending appeal if the appeal is filed within 30 days of the notice of denial.

2. Within 20 days from date appeal is filed:

- Check on appeal status and if additional assistance is needed with the appeal.

3. Within 90 days from date appeal is filed:

- Check on final outcome of appeal.

Notice of Denial - **FFS**

For FFS:

4. Enter the following information into the EPSDT PA Tracking Log:

- Date Denial of Service Notice Received
- Approval/Denial Status
- Reason for Denial
- Date Appeal Rights Explained
- Date Appeal Brochure Provided
- Offered to Help with Appeal Date
- Is Client Appealing
- Request Assistance with Appeal
- Date Appeal Sent to LDH
- 20 Day Appeal Follow Up
- 90 Day Appeal Follow Up
- Date of Appeal Decision
- Appeal Outcome

Appeals / Reduction in Service for MCO

For services authorized by the MCO that are denied or partially denied, the beneficiary, provider, and the Support Coordinator will receive notice of denial. The beneficiary may appeal the decision by following the appeals procedures sent to them, the provider, and the Support Coordinator by the MCO following the denial or partial denial. If you do not have a copy of the denial notice, refer to the MCO's member handbook to review the MCO's internal appeals procedure; member handbooks can be found at: https://ldh.la.gov/page/member-handbooks.

The support coordinator must inform the beneficiary of his/her Appeal rights, go over the Appeals Brochure that both parties received from the Managed Care Organization, and offer to assist the beneficiary with the appeal process/fair hearing if the beneficiary decides to request an appeal.

If the internal Managed Care Organization appeal decision is upheld, the beneficiary has the right to appeal to the Department of Administrative Law.

Notice of Denial - **MCO**

For MCO

1. Within 4 calendar days from the notice of denial:

- Explain appeal rights and offer assistance
- Explain that the provider can request a peer-to-peer review.
- Explain circumstances in which continued benefits are provided on appeal under Managed Care. A member is only entitled to a continuation of benefits pending resolution of an appeal or state fair hearing when a previously authorized benefit is terminated, suspended, or reduced prior to the expiration of the current service authorization.

2. Within 20 days from date appeal is filed:

- Check on outcome of appeal.

Notice of Denial - **MCO**

For MCO

3. Enter the following information into the EPSDT PA Tracking Log:

- Date Denial of Service Notice Received
- Approval/Denial Status
- Reason for Denial
- Date MCO Appeal Rights Explained
- Offered to Help with MCO Appeal Date
- Is Client Appealing
- Request Assistance with MCO Appeal
- Date Appeal Sent to MCO
- 20 Day MCO Appeal Follow Up
- Date of MCO Appeal Decision
- MCO Appeal Outcome
- MCO Appeal Notes

Notice of Denial - **MCO**

For MCO - After the Medicaid Managed Care appeal is exhausted, Division of Administrative Law (DAL) State Fair Hearing (SFH):

1. Within 4 calendar days from the notice of appeal denial from the MCO: Explain DAL State Fair Hearing right rights and offer assistance

2. Within 20 days from date appeal is filed: Check on appeal status and if additional assistance is needed with the appeal.

3. Within 90 days from date appeal is filed: Check on final outcome of appeal.

Notice of Denial - **MCO**

For MCO - After the Medicaid Managed Care appeal is exhausted, Division of Administrative Law (DAL) State Fair Hearing (SFH):

4. Enter the following information into the EPSDT PA Tracking Log:

- Date Appeal Rights Explained
- Date Appeal Brochure Provided
- Offered to Help with Appeal Date
- Is Client Appealing
- Request Assistance with Appeal
- Date Appeal Sent to LDH
- 20 Day Appeal Follow Up
- 90 Day Appeal Follow Up
- Date of Appeal Decision
- Appeal Outcome

Appeals / Reduction in Service

For FFS or for MCO after the internal appeal process has been exhausted:

- If services are denied or partially denied or for any individual whose claim for medical assistance under the plan is not acted upon with reasonable promptness or if the member alleges that services are not made available with reasonable promptness, the beneficiary may appeal by: mailing or faxing a written request for a fair hearing to the Division of Administrative Law ("DAL"), Health and Hospitals Section, by calling 225-342-0443, or by filling out the form at http://laserfiche.adminlaw.state.la.us/Forms/hSgLX

- The support coordinator must inform the beneficiary of his/her Appeal rights and provide the Appeals Brochure *(Appendix L).* Review the brochure in its entirety. Information on appeals can be located on the internet at: http://new.LDH.louisiana.gov/index.cfm/page/323

Renewals

For FFS: 45-60 days prior to the end of the PA period, begin the Renewal Process.

For MCO: 20-60 days prior to the end of the PA period, begin the Renewal Process.

Renewals

For FFS: The provider must submit the packet no less than 25 days prior to expiration of the prior authorization for services to continue without interruption. Some services may not require a full prior authorization packet.

For MCO: The number of days prior to expiration that the provider must submit the packet for prior authorization for services to continue without interruption varies from plan to plan. See *MMC Appendix D.* Some services may not require a full prior authorization packet.

Renewals

Enter the Date Renewal Sent and open a new EPSDT PA Tracking Log; choose Renewal.

Keep the Date of Service request the same as the previous tracking log.

Enter a new date of COP. This is the date you started the Renewal and confirmed the beneficiary wants to stay with their current provider.

Send *Appendix V-1 - Referral to Provider* to remind the provider to renew the PA. Enter this date in the Date of Referral to Provider box on the EPSDT PA Tracking Log.

Renewals

If you have not received a notice of approval from the Fiscal Intermediary Gainwell Technologies for FFS or the beneficiary's MCO for Managed Care for the renewal and the previous PA expired:

Send Appendix V-2 - Referral to PAL – check box 3.

Other Issues

If the beneficiary needs a schedule change:
Send *Appendix V-1 - Referral to Provider* – check box 2.

If the provider needs to submit additional information with the PA request and you received a PAL notice:
Send a *Appendix V-1 - Referral to Provider* – check box 4.

Other Issues

If service is not provided at the times requested:
Send *Appendix V-2 - Referral to PAL* – check box 6.

If service is not provided in the amount Prior Authorized:
Send Appendix V-2 - Referral to PAL – check box 7.

If at any time the provider is not working on behalf of the beneficiary:
Send *Appendix V-2 - Referral to PAL* – check box 8.

BARRIERS

What if the beneficiary is placed on a waitlist?

If at any time a beneficiary is placed on a waitlist for a needed service, the SC must document that the class member was offered alternative providers for whom there is not be a waiting list and the response received.

For services that require a PA, the SC must complete the*Appendix V-2 - Referral to PAL* – check box 5 and answer questions. The SC must indicate if they were able to confirm waitlist placement with the provider or if they need assistance from the PAL to do so. The SC must document if the family declined alternative providers or if the PAL needs to assist with locating alternative providers. The SC must indicate the date the beneficiary was placed on the waitlist and the estimated wait time.

The SC must follow up on waitlist placement with the provider at least monthly to ensure they move up the waitlist.

What if you are unable to locate a willing and able **FFS** provider?

If you are unable to locate a Medicaid FFS provider for a Chisholm class member, **call the contact person listed on *Appendix E - Medicaid Services Chart*** for assistance. Make sure you contact the correct Program Subject Matter Expert when information is needed (i.e. DME staff for DME related services, etc.)

If the service contact person is unable to assist, **call the LDH Program Staff Line at 1-888-758-2220** and tell them you cannot find a provider. The LDH program staff line's hours of operation are 8:00a.m.- 4:30p.m. with a voice mail message system for overflow and after hour calls.

The Support Coordinator must complete ***Appendix V-2 - Referral to PAL –*** check box 4.

If a provider cannot be located, LDH must take all reasonable and necessary steps to find a willing and able provider within ten days.

What if you are unable to locate a willing and able **MCO** provider?

If you cannot find a provider from the Medicaid Managed Care Program website, or the provider directory, which is willing to submit a prior authorization request **call the MCO's member service line** which operates from 7am-7pm, M-F, for assistance.

The Support Coordinator completes ***Appendix V-2 - Referral to PAL*** – check box 4 to notify the MCO of the inability to locate a willing provider. **The MCO will take all reasonable steps to find a willing and able provider within ten days.**

If the MCO is unable to locate a willing provider within 10 working days of the referral, the MCO must alert the Chisholm Compliance team. This alert should include the actions taken and reasons why the member's services are not in place. The MCO is contractually responsible for ensuring that services are provided for its beneficiaries including finding an in-home provider within 10 working days of the Referral to PAL. The MCO may pursue a single case agreement in order to obtain a willing provider.

What if a FFS provider is unable to find staff?

If the provider is unable to find staff after the service has been approved, the support coordinator must complete ***Appendix V-2 - Referral to PAL.***

The support coordinator must **call the LDH program staff line** at 1-888-758-2220.

The support coordinator should assist the family in finding another provider agency with available staff from the LDH website list of providers.

If a provider cannot be located, LDH must take all reasonable and necessary steps to find a willing and able provider within ten days.

What if a **MCO** provider is unable to find staff?

If the provider is unable to find staff after services have been approved **call the MCO's member services line** which operates from 7am-7pm, M-F, for assistance.

Support Coordinators must complete ***Appendix V-2 - Referral to PAL*** to request assistance from the MCO. **The MCO will take all reasonable steps to find a willing and able provider within ten days.**

If the MCO is unable to locate a willing provider within 10 working days of the referral, the MCO must alert the Chisholm Compliance team. This alert should include the actions taken and reasons why the member's services are not in place. The MCO is contractually responsible for ensuring that services are provided for its beneficiaries including finding an in-home provider within 10 working days of the Referral to PAL. The MCO may pursue a single case agreement in order to obtain a willing provider.

Part 5

EPSDT SUPPORT COORDINATION REQUIREMENTS

Monitoring and Follow-up Activities

Support Coordination includes the following assistance:

- Monitoring and follow-up activities: activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the beneficiary's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's are plan;
  - Services in the care plan are adequate; and
  - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring and Follow-up Activities

Support Coordination includes the following assistance:

- A minimum of one face-to-face visit per quarter with each beneficiary (and their guardian) is required. More frequent face-to-face visits shall be required to be performed if indicated in the beneficiary's CPOC. Additional face-to-face visits may be performed if needed to obtain services.

Monitoring and Follow-up Activities

- Two quarterly visits that are not the initial or annual plan of care visit, are allowed to be conducted virtually when the following conditions are met:
  1. The beneficiary/family is in agreement that a virtual visit is in the best interests of the beneficiary;
  2. The support coordinator is in agreement that a virtual visit is in the best interests of the beneficiary;
  3. The provider agencies are in agreement that a virtual visit is in the best interests of the beneficiary;
  4. The legally responsible individual or family members living in the home are not paid caregivers;
  5. Technology is available to complete the visit with direct observation of the beneficiary and the home;
  6. There is evidence that the requirements for the quarterly visit can be completed virtually.

Virtual Visit Criteria

- Must be initiated by the beneficiary.
- The beneficiary and guardian must be present.
- Beneficiary and SC must have a device with a camera, format capabilities and internet services necessary to complete a virtual visit that includes the ability for the SC to view the beneficiary/family and the beneficiary/family understand how to utilize the virtual format. If the beneficiary does not have access to Telehealth the visit must be completed face-to-face.
- Beneficiary understands HIPAA requirements for use of a virtual format.
- Must be able to obtain electronic signature using a HIPAA protected platform for electronic signature. Agency using electronic options accepts responsibility to assure compliance with all federal regulations for retention.
- No more than two quarterly visits can be completed virtually per calendar year. At least one Quarterly Visit/Reassessment must occur face-to-face each calendar year.

Monitoring and Follow-up Activities

The beneficiary and the legal guardian must always be present to conduct an initial CPOC assessment, an annual CPOC assessment or a quarterly visit reassessment.

The original signature page must be kept in the case record.

Location of Meetings:

- The Initial and Annual face-to-face CPOC meeting must be held at the beneficiary's home.
- Other meetings (Quarterly visit reassessments) can take place at the location of the beneficiary's choosing.
- Support Coordinators are allowed to utilize telehealth in place of two face-to-face quarterly reassessments that are NOT the initial/annual comprehensive plan of care meeting.

Monitoring and Follow-Up Activities

Through monitoring and follow-up, the SC not only determines the effectiveness of the CPOC in meeting the beneficiary's needs, but identifies when changes are needed to the CPOC.

The purpose of follow-up/monitoring contacts is to determine:

- if supports are being delivered as planned;
- if supports are effective and adequate to meet the beneficiary's needs;
- whether the beneficiary is satisfied with the supports.

Monthly Contact

Every calendar month after linkage, the support coordinator must make contact with the beneficiary to address the following:

- If services are being received;
- If they're satisfied with the services and their provider;
- Any assistance provided with identified needs and problems with providers;
- Offer of services for identified needs;
- If the beneficiary wants to receive any medically necessary therapies outside of the school setting, in addition to those they receive in school, and if the beneficiary wants to receive these therapies during the school's summer break;
- The Freedom of Choice;
- Information regarding the requirements to obtain a PA for the services requested was given to the beneficiary;
- Follow up on obtaining information to obtain the PA request;
- Assistance with appeals;
- Determination of service start date after the PA is received;
- If the beneficiary is progressing with the current services and/or IEP services;
- Any behavior concerns or issues.

As Needed Contact

The support coordinator must make contact with the beneficiary **as needed** until each service included on the CPOC is fully implemented, including receipt of all prior authorized services. Contacts may be required to:

- Assure implementation of requested services,
- Determine a service start date after the PA is received,
- Assist, as requested, with identified needs and problems with providers,
- Follow up on obtaining information to complete a PA request,
- or to offer assistance with an appeal.

Do NOT wait until the next monthly contact.

Quarterly Review

The support coordinator must complete a Quarterly Review with the beneficiary and parent/legal guardian each quarter in order to identify:

- Service needs and status through review of the CPOC. The service needs section of the Quarterly Review should document if services are received and if the beneficiary/family is satisfied with their services and their providers.
- Additional services requested
- Scheduling issues (update the Typical Weekly Schedule)
- Completion of the EPSDT CPOC Quarterly Review/Checklist and Progress Summary located in LSCIS.

LSCIS Quarterly Review

Service Needs	Requesting Services	Receiving Services	Expiration Date of PA	Reffered to PAL	Appeal Process	Progress Status of Service/ Receiving amount PA
Diapers (1) incontinence	☑	☑				ongoing through Medcare
Other (3) APE	☑	☑	NA	NA NA	NA	ongoing through school
Other (5) Health Plan	☑	☑	NA	NA NA	NA	ongoing through school
Other (7) Cardiologist	☑	☑	NA	NA NA	NA	ongoing
Other (8) Developmental Doctor	☑	☑	NA	NA NA	NA	ongoing
Other (9) Orthopedist	☑	☑	NA	NA NA	NA	ongoing
Personal Care Service (1) assist with ADL's	☑	☑	07/31/2022			Ongoing through Community Connections
Speech Therapy (1) improve speech	☑	☑	NA	NA NA	NA	ongoing through school

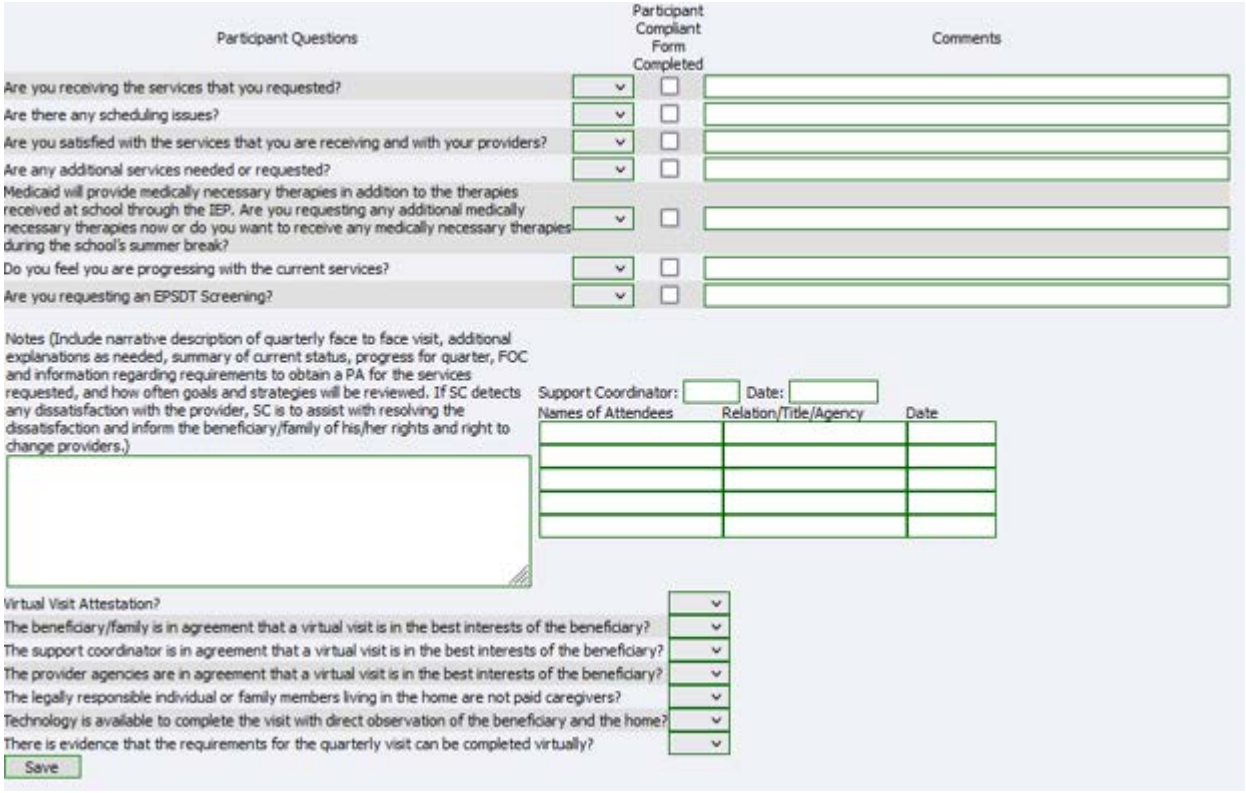
Current Status:

Health Changes (include Nutritional Changes)		
Safety Issues		
Behavior Issues and Concerns		
Changes in Living Situations		

Review of the following occurred:

Medicaid Services Chart (Appendix B)	
Services Available to Medicaid Eligible Children Under the Age 21 (Appendix F)	
Rights and Responsibilities (Appendix K)	
Appeal Process (Appendix L)	
Complaint Process for filing a report against support coordinators and/or Legacy Medicaid providers; HSS 1-800-660-0488 (Appendix M)	
Chisholm Class Members right to choose between Legacy Medicaid and the Medicaid Managed Care Program for their physical health services (Medicaid Managed Care Appendix H)	
Complaint Process for filing a report against Managed Care Organizations or Medicaid Managed Care Program providers; Healthy Louisiana Line 1-855-229-6848 (MMC Appendix I)	
SC Agency 24 Hour Toll-Free Number	
HIPPA and Confidentiality Notification	
Grievance Policy	
Abuse Policy	
Availability of EPSDT Screening	
Availability of formal and non-formal services	

LSCIS Quarterly Review



Participant Questions	Participant Compliant Form Completed	Comments
Are you receiving the services that you requested?		
Are there any scheduling issues?		
Are you satisfied with the services that you are receiving and with your providers?		
Are any additional services needed or requested?		
Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP. Are you requesting any additional medically necessary therapies now or do you want to receive any medically necessary therapies during the school's summer break?		
Do you feel you are progressing with the current services?		
Are you requesting an EPSDT Screening?		

Notes (Include narrative description of quarterly face to face visit, additional explanations as needed, summary of current status, progress for quarter, FOC and information regarding requirements to obtain a PA for the services requested, and how often goals and strategies will be reviewed. If SC detects any dissatisfaction with the provider, SC is to assist with resolving the dissatisfaction and inform the beneficiary/family of his/her rights and right to change providers.)

Support Coordinator: Date:

Names of Attendees	Relation/Title/Agency	Date

Virtual Visit Attestation?	
The beneficiary/family is in agreement that a virtual visit is in the best interests of the beneficiary?	
The support coordinator is in agreement that a virtual visit is in the best interests of the beneficiary?	
The provider agencies are in agreement that a virtual visit is in the best interests of the beneficiary?	
The legally responsible individual or family members living in the home are not paid caregivers?	
Technology is available to complete the visit with direct observation of the beneficiary and the home?	
There is evidence that the requirements for the quarterly visit can be completed virtually?	

Save

Complaints

If any complaints against support coordinators or Medicaid FFS providers are detected as a result of the Quarterly Review, the beneficiary should be given *Appendix Q - Complaint Form* to complete and return to Health Standards.

If the beneficiary has a complaint against their Managed Care Organization or an MCO provider, they should be given *Appendix R – Managed Care Complaints* which includes the Medicaid Managed Care Program Assistance Line at 1-855-229-6848 and the healthy@la.gov e-mail address for filing complaints against an MCO or an MCO provider.

Dissatisfaction with a Provider

If the Support Coordinator detects the beneficiary has any dissatisfaction with a service provider, it is the Support Coordinator's responsibility to assist the beneficiary in resolving any problem and to let the beneficiary know of his/her right to change providers.

If the issue cannot be resolved, the support coordinator will:

- Alert the PAL and Send *Appendix V-2 – Referral to PAL*

Adjustments to the CPOC

Changes to the CPOC, including the Typical Weekly Schedule, should be made:

- When there is a change in the needs or status of the beneficiary.
- To reflect the changes if prior approval of a requested service is denied (and not successfully challenged through a fair hearing request or other advocacy).
- When strategies are needed to deal with problems with services or providers. Resolving problems and overcoming barriers to beneficiaries' receiving services is a key goal of the CPOC process.
- When significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment. The CPOC should be updated and goals and objectives should be added and/or revised according to the most recent information available.

Documentation

If it is not documented for compliance purposes, it is as if it did not happen. Documentation proves that Chisholm protocols and procedures were followed.

LSCIS Service Log

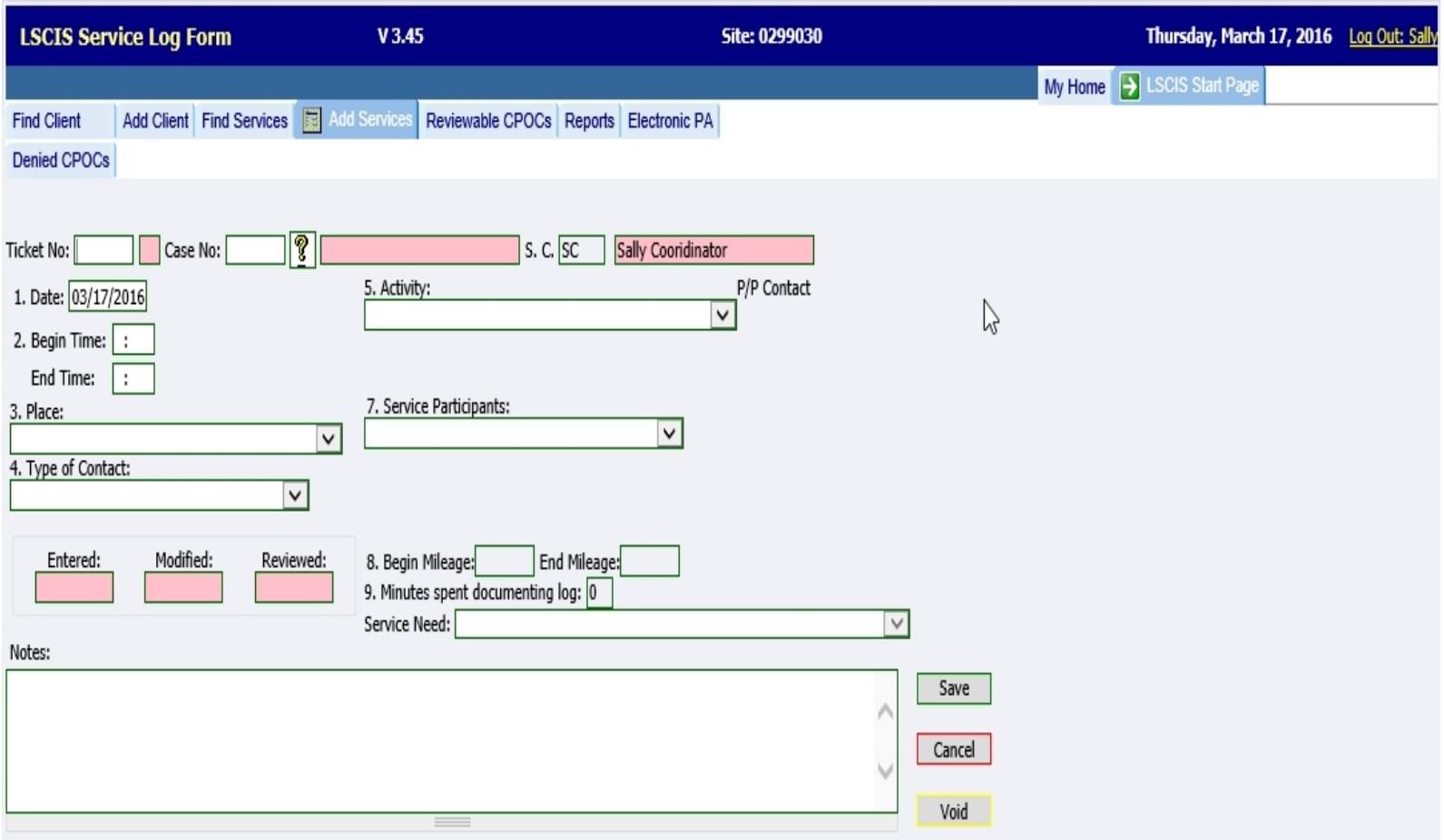
The LSCIS Service Log should be used to provide **a narrative of activities** related to the request for EPSDT services including each activity and contact with the provider, the beneficiary, and the PAL.

A separate service log should be used to document activity related to a specific prior authorized service.

The LSCIS Service Log should be used for documenting all contacts with the beneficiary, provider, MCO, SRI, LDH Program Staff Line and PAL. The service log should also be used to document the receipt or the approval, denial or reduction of services, the monthly contact with the beneficiary/family regarding the status of implementation of services, and all support coordination activities.

These entries must be up to date as BHSF/SRI and/or Health Standards may request to review this information in order to verify services and prior authorization information.

LSCIS Service Log



Signatures

Conduct the meeting using the PRINTED copy of the CPOC and/or Quarterly Review. A service strategy list is included to assist in identifying additional service needs. The attendees (everyone present at the meeting including yourself) will sign and date the hard copy.

CPOC:

- All participants must sign in the Planning Participants box as documentation of who was present at the meeting.
- The Participant/Guardian must sign on the Participant/Guardian signature line.
- The SC must sign on the SC signature line.
- The SC Supervisor must sign on the SC Supervisor Signature line.

Quarterly Review:

- All participants must sign in the Quarterly Meeting Attendees box as documentation of who was present at the meeting.
- The Participant/Guardian must sign on the Participant/Guardian signature line.
- The Support Coordinator will sign the Support Coordinator Signature line.

Signatures

Acceptable signatures include:

- Original (hard) signatures required for Initial/Annual CPOC assessments and face-to-face Quarterly Reassessments
- HIPAA protected platform for electronic signature for **virtual** Quarterly Reassessments
  - Participant/family is able to and agrees to use the electronic signature option
  - Agency using electronic options accepts responsibility to assure compliance with all federal regulations for retention

Any time a participant/family says they want to view or sign a plan in person this MUST be accommodated.

No "verbal signatures" are allowed.

Signatures

Signatures are required as documentation of:

- who was present at the meeting,
- the date the meeting was held,
- all service needs and supports were reviewed,
- SC reviewed all required information,
- Participant/Guardian agrees with the services contained in the plan and with the Participant/Guardian statement,
- SC agrees with SC statement, and
- SCS reviewed CPOC and agrees with SCS statement.

EPSDT Quarterly Report

The EPSDT Quarterly Report is due to BHSF/SRI by the 5th day of the month following the end of the quarter:

1st Quarter Due: **April 5**
2nd Quarter Due: **July 5**
3rd Quarter Due: **October 5**
4th Quarter Due: **January 5**

The SCA must use *Appendix W-1 – Checklist for EPSDT Quarterly Report* and:

- A print out of the Quarterly Report From LSCIS (reviewed and signed)
- *Appendix W-2 – EPSDT Quarterly Report of Revised CPOCs* with a print out of the Service Needs Changes Report attached.
- *Appendix W-3 - Record Review* for each PA not issued within 60 days and each Gap in Prior Authorization Periods. A separate record review is required for each beneficiary and each service need.
- Explanation of beneficiaries without a Choice of Provider
- Documentation of EPSDT Training for any new hires; *Appendix W-4 – Training Log.*

EPSDT Quarterly Report

The EPSDT Quarterly Report will be completed using information entered into LSCIS. Each agency must have all of the required information entered into LSCIS at the end of each quarter so that the report can be generated.

It is the responsibility of the Agency to identify beneficiaries with a PA not issued within 60 calendar days of the beneficiary's request and beneficiary's with a gap in authorization period. As part of that identification, the Agency must review all documentation (CPOC, PA Tracking Log, Service Logs, etc.) prior to the end of each Quarter.

EPSDT Quarterly Report

The EPSDT Quarterly Report will include the names of the beneficiaries and the services for the following:

- Beneficiaries with PAs not issued within 60 calendar days of date of choice of provider
- Beneficiaries with service gaps in the authorization periods
- Beneficiaries who submitted requests for appeals within the quarter.

Appendix W-3 - Record Review is to be completed for each beneficiary and each service need listed on the LSCIS Quarterly Report as PAs not issued within 60 calendar days or a Gap in Authorization Period. A separate record review is required for each service need listed.

For Record Reviews for gaps: If no gap is found or the gap was due to the family's choice fill out page one of the Record Review to document this and then remove it from the Quarterly Report.

The EPSDT Specialist, if they are not the Support Coordinator involved, is to complete the record review. If the Support Coordinator involved in these cases is the EPSDT Specialist, then the supervisor or on-site program manager are to complete the record review.

EPSDT Quarterly Report

Either the number of trackings without a choice of provider must be zero or documentation and explanation must be attached for each beneficiary and each service need without a choice of provider.

BHSF/SRI and the LDH attorney will review the information to assure that the beneficiaries are receiving the services they need and the assistance they need to access the services. BHSF/SRI will request supporting documentation and information from the support coordination agencies as needed.

EPSDT Training

All **Support Coordinators, Trainers and Supervisors** must receive EPSDT training.

- New support coordinators and trainees, designated trainers and supervisors must receive EPSDT training:
  - during orientation, and
  - prior to being assigned an EPSDT caseload or beginning supervision of EPSDT support coordinators.
- All support coordinators and trainees, designated trainers and supervisors must complete EPSDT training each year as part of their 20 hours of annual training. The agency's Designated Trainer and Supervisors will be responsible for training the staff. Training for the designated trainer and supervisor(s) may be provided by BHSF/SRI or by a trained supervisor or designated trainer within the agency.

EPSDT Training

The agency must submit documentation of the training to the EPSDT SC Contractor (SRI) using the Training Log - *Appendix W-4.*

- Documentation of annual training must be submitted one time each year.
- Documentation of training for any new staff must be submitted by the last day of each quarter.

Compliance

The On-Site Program Manager is responsible for assuring compliance with all program requirements and the EPSDT Specialist is to monitor that all EPSDT requirements are met.

The Program Manager and EPSDT Specialist shall both check the LSCIS reports at least semi-weekly. All deficiencies are to be addressed and resolved.

Refer to Handbook – LSCIS Reports section.

Reminders

The purpose of Support Coordination is to coordinate **all** services and to ensure the beneficiary receives the services he/she needs.

If at any time a provider is not actively working on behalf of the beneficiary, contact the PAL.

Contact SRI if you have questions regarding EPSDT SC or to report issues or concerns with obtaining services for beneficiaries.

Contact BHSF State Office for any policy questions.

CMS Best Practices for Adhering to EPSDT Requirements

"The EPSDT mandate represents a critical part of the Medicaid program that is designed to ensure eligible children have access to essential medical, dental, behavioral health, and developmental services from an early age. As Medicaid has grown more complex, navigating access to these services has become more difficult, **with coordination and assistance ever more important to access care**. The collective effort and shared commitment of CMS, state Medicaid agencies, health care providers, and caregivers is essential in advancing the coverage goal of EPSDT – the right care, to the right child, at the right time, in the right setting – to help ensure children in Medicaid have the opportunity to reach their full health potential."

-Daniel Tsai, Deputy Administrator and Director

Questions/Comments

Questions and Answers will be sent out with the Training Module.

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Questions/Comments

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