EPSDT SC TRAINING QUESTIONS AND ANSWERS

11/20/2024
9:30 AM
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PART ONE - OVERVIEW

1. **How can we access the slideshow from this training?**
   You can access all of the EPSDT SC Training Materials including the slide show, Handbook, and Appendices via: https://ldh.la.gov/page/4981.You can also contact Kim Willems at SRI via e-mail at ksalling@statres.com or phone at 225.767.0501 to request a copy of any training materials.

2. **When does a child become a Chisholm class member?**
   Children do not become Chisholm class members until they are 3 years old because that is when they can be placed on the Developmental Disabilities Request for Services Registry through the Office for Citizens with Developmental Disabilities or their local governing entity (LGE). They may have a "protected Registry date" prior to age 3, but until they are formally found eligible for the Developmental Disabilities services system, they are not Chisholm class members. They also must qualify for Medicaid.

3. **How do Chisholm class members that are linked to Healthy Louisiana access EPSDT SC?**
   EPSDT SC is option but, if they would like EPSDT they may contact Statistical Resources, Inc. (SRI) at 1-800-364-7828 and request an EPSDT Support Coordination Freedom of Choice. They'll speak to Ms. Pat Carter. If they are not yet on the Request for Services Registry, they will be referred to their LGE. If they are already linked to Waiver, they will receive support coordination for all services from their Waiver support coordinator.

4. **How do members benefit from switching from fee-for-service Medicaid to a health plan**?
   Healthy Louisiana is the State's managed care program for Medicaid recipients. Six private companies contract with the state to manage the acute health needs of individuals who are enrolled. Some of these health plans have a different network of doctors, hospitals, and other providers than traditional Medicaid which may mean their provider network is larger than Legacy Medicaid. It's very important that individuals and their families look closely at the potential advantages and disadvantages of enrolling in Healthy Louisiana before making this decision. Benefits may include access to a different set of medical providers. The managed care company will be determining the services, amounts, and duration of services to be received. The managed care company has to provide the same amount, duration, and scope as

traditional Medicaid. In addition, some plans offer incentives for successfully meeting certain outcomes. You can compare plans at: https://www.myplan.healthy.la.gov/en/compare-plans.

5. **If a Chisholm class member wants to enroll or disenroll from a health plan, who do they contact?**
   To enroll or disenroll from the Health Plan, members can call 1-855-229-6848. For more information on opting-in and disenrolling from the Health Plan refer to Appendix S.

PART TWO – SERVICES AVAILABLE TO EPSDT BENEFICIARIES

ABA

6. **What can be used in place of a Clinical Diagnostic Evaluation (CDE)?**
   A psychological evaluation, psychiatric evaluation, special education evaluation, etc. may be used in place of CDE if ABA is recommended.

Behavioral Health Questions

7. **What is short term respite available through the CSoC Waiver?**
   Respite is designed to help meet the needs of the caregiver and the child. The respite provider cares for the youth or child in the child's home or a community setting to give the caregiver/guardian a break. Children or youth in CSoC can receive up to 300 hours of respite each year. This service helps to reduce stressful situations. Respite may be planned or provided on an emergency basis.

8. **Can LDH define "specialized behavioral health services"?**
   See EPSDT Handbook page 15 - Specialized Behavioral Health Services.

9. **What are age limitations on the various behavioral health services?**

Behavioral Health Service Type	Target Population
Assertive Community Treatment	Individuals **18 years of age or older** who have a severe or persistent mental illness.
Child-Parent Psychotherapy	Children **ages 0-5** and caregivers who have experienced trauma.
Coordinated System of Care (CSoC)	Children **ages 5-20** with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement.
Eye Movement Desensitization and Reprocessing	Children **ages 2-18** with a history of trauma who are experiencing post-traumatic stress disorder symptoms.
Functional Family Therapy	At risk youth **ages 12-18** and their families.
Functional Family Therapy: Child Welfare	Youth **ages 0-17** and families in child welfare settings.
Homebuilders	Families with children **ages 0-18** at risk of placement into foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities OR children already in these placements who need therapy before returning home.

Multisystemic Therapy	Youth **ages 12-17** with possible substance use issues who are at risk of out-of-home placement due to dysfunctional or delinquent behaviors. Youth involved with the juvenile justice system.
Opioid Treatment Programs	Individuals **18 years of age or older** with opioid use disorder.
Parent-Child Interaction Therapy	Children **ages 2-7** with behavior problems and dysfunctional relationships with parents/caregivers. Treatments involve parents, foster parents, or other caretakers.
Preschool PTSD Treatment	Children **ages 3-6** with post-traumatic stress disorder symptoms.
Trauma-Focused Cognitive Behavior Therapy	Children **ages 3-18** with a known history of trauma who are experiencing post-traumatic stress disorder symptoms.
Triple P	For parents and caregivers of children and adolescents **ages 0-12** with moderate to severe behavioral and/or emotional difficulties.
Youth PTSD Treatment	Children and adolescents **ages 7-18** with post-traumatic stress disorder symptoms.

The Evidence Based Program Referral Guide has a breakdown of EBPs by age of child, focus, and place of service: https://laevidencetopractice.com/wp-content/uploads/2023/01/EBP-Referral-Guide.pdf

EPSDT-PCS

10. Who can be an EPSDT-PCS direct support worker?

Refer to the EPSDT-PCS provider manual section 30.18 Staffing.

EPSDT-PCS services shall be provided by an individual who meets the following qualifications:

- Must be at least 18 years of age at the time the offer of employment is made;
- Must have the ability to read and write in English, and to carry out directions
  - promptly and accurately; and
- Must pass a criminal background check.

Staff assigned to provide personal care services shall NOT be a member of the beneficiary's immediate family. Immediate family includes:

- Father;
- Mother;
- Sister/brother;
- In-law;
- Grandparent;
- Curator;
- Tutor;

- ❖ Legal guardian;
- ❖ Beneficiary's responsible representative; or
- ❖ Person to whom the beneficiary has given representative and mandate authority (Power of Attorney).

The PCS may be provided by a person of a degree of relationship to the beneficiary other than immediate family, only if the relative is not living in the beneficiary's home, or, if he/she is living in the beneficiary's home solely because his/her presence in the home is necessitated by the amount of care required by the beneficiary.

11. **What should an SC do if an EPSDT-PCS provider is telling the family incorrect information, like saying an immediate family member can be the worker**?
    Refer the provider to the EPSDT-PCS provider manual. The public health emergency ended on May 11, 2023. Refer to LDH Informational Bulletin 23-5. Complaints regarding service providers can be made to Health Standards Section at 1-800-660-0488.

12. **How much EPSDT-PCS can be approved?**
    The number of hours approved is based on medically necessary activity of daily living assistance for the beneficiary. There are no set limits to the number of hours a beneficiary can receive.

13. **Do you need a prescription from the practitioner or does the form 90 act as the prescription?**
    Section IV. Practitioner's Order of the form 90 acts as the prescription and a separate prescription on a prescription pad is not needed.

14. **How are chronic needs defined?**
    This is in both the Personal Care Services policy manual under the EPSDT section and also in the rule.

15. **What can an SC do if a Prior Authorization request is partially denied because there wasn't enough documentation to support the request?**
    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. Follow the appeal process. If documentation is obtained to support the request you can file an appeal or the provider can submit a reconsideration request.

16. **Can a Waiver beneficiary receive EPSDT-PCS services?**
    Yes, if they are under the age of 21 and it is deemed medically necessary. All Waiver beneficiaries are Medicaid eligible so they have access to the full range of services available through the Louisiana State Plan. Their Waiver SC is responsible for coordinating all Wavier and non-Waiver services including all Medicaid services. Refer to Appendix I and BB-7. Waiver beneficiaries must exhaust all available state plan services, including Medicaid, before using OCDD waiver funds.

17. **Can a beneficiary receive EPSDT SC without requesting/receiving PCS?**
    Yes, EPSDT encompasses much more than PCS. EPSDT-PCS is a specific Medicaid service for assistance with ADLs. The EPSDT benefit refers to Medicaid for children. All Medicaid eligibles under age 21 are entitled to Medicaid coverage of all health care, diagnostic services, treatment, and other measures 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.

18. **Do you have to receive Support Coordination to get PCS?**
    No, EPSDT SC is an optional service and has no effect on a beneficiary's eligibility to receive any Medicaid Service.

19. **Are PCS providers aware that they need to submit the PA packet to the MCO and not Gainwell for managed care members?**
    Yes. If a provider needs assistance, refer them to Provider Relations:

Gainwell Technologies (Fee-for-Service Medicaid)	1-800-473-2783
Aetna Better Health	1-855-242-0802
AmeriHealth Caritas	1-888-922-0007
Healthy Blue	1-844-521-6942
Humana Healthy Horizons in Louisiana	1-800-448-3810
Louisiana Healthcare Connections	1-866-595-8133
UnitedHealthcare Community Plan	1-866-675-1607

Physical Health Questions

20. **Can a beneficiary receive Pediatric Day Healthcare and Extended Home Health?**
    Yes, if it is medically necessary. EPSDT beneficiaries can receive as many doctor visits, hours, and amounts of any services as are medically necessary for their individual conditions. There are NO fixed limits on ANY service.

21. **Issues with diaper providers not accepting members with private insurance. Or getting PA from Medicaid and then having to pay Medicaid back.**

Other Services

22. **How do you access services not covered by Medicaid such as hippotherapy or art therapy?**
    First, do not assume that a service is not covered by Medicaid. Although a service may not be listed on the Medicaid Services chart, 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. After a service is denied by Medicaid and the appeal is exhausted, the SC should then assist the family with

exploring available community resources. If another avenue cannot be found, the SC can then submit a family support request to OCDD to request funding.

PART THREE – COMPONENTS OF SUPPORT COORDINATION

23. Is EPSDT Targeted Population Participant Complaint Form to be filled out by the SC or the participant?

The form is to be completed and signed by the person making the complaint. If any complaints are detected as a result of the EPSDT CPOC Quarterly Review/Checklist and Progress Summary, the participant should be given the Participant Complaint form (Appendix M) to complete and return to Health Standards. If the Support Coordinator detects the participant has any dissatisfaction with a service provider, it is the Support Coordinator's responsibility to assist the participant in resolving any problem and let the participant know of his/her right to change providers.

24. What are common CPOC deficiencies?

- Current formal document must be on file.
- If receiving Special Education Services, the current IEP must be on file.
- Must clearly document what formal documentation you have on file to support diagnosis (i.e., "2023 IEP documents developmental delay.")
- Service Needs must match what's in body of CPOC. Clearly identify if all identified service needs are requested, on hold or declined. If you see a need, you must offer the service and document the response.
- All inconsistencies must be resolved. Delete old information or information that is no longer relevant or accurate. What is stated in the Present must match what's in the service needs, additional information, service logs, etc.
- All service needs must be captured. Refer to Handbook page 53-58.
- Incorrect reason selected for "if not why not" on the Service Need. Refer to Handbook.
- PA tracking box is not checked or incorrect reason selected for reason for not tracking.
- Additional information missing required information related to service needs like provider name, status, barriers, strategies to obtain, reason for not tracking + how you'll assure it's received, waitlist placement info, etc.

PART FOUR – COORDINATION OF SERVICES

25. How does an SC handle request for Medicaid services when the beneficiary has private insurance?

Provider must obtain one of the following from the primary insurance to submit the request to Medicaid who is secondary insurance:

- An Explanation of Benefits (EOB) identify the reason for the denial or,
- A copy of the beneficiary's coverage manual if the member's primary insurance coverage manual indicates that the requested service is not a covered service, a copy of that information should be sufficient.

If the primary payer denial was not based on medical necessity, Medicaid should approve the service. Unfortunately, if the denial was based on the beneficiary not meeting medical necessity, Medicaid can deny the service.

26. If the MCO cannot find a provider, what will LDH do?

LDH will not find the provider for the member. The MCO is contractually responsible for ensuring that services are provided for its members. LDH will reach out to the MCO when a PAL referral is received to ensure that this contractual obligation is met. The MCO may pursue a single case agreement. Ultimately, it is up the MCO to ensure the recipient receives all services that they are entitled to receive.

27. How will support coordinator's handle the Freedom of Choice process for Healthy Louisiana?

They will use the same Choice of Provider form. You can access a list of providers for the MCOs via each MCO's website, Healthy.la.gov (scroll down and click Find a Provider) or by calling the MCO's Member Services Line. The family can give a verbal Choice of Provider (COP) to the Support Coordinator per phone if it is needed for a timely referral to the provider. In order to do this, the family must have a list of providers or know who they want. The Support Coordinator may not give a partial list of providers to the family to choose from. The Support Coordinator must complete the Choice of Provider Form documenting the client's choice of provider and have another office employee speak with the family to confirm and witness the Choice of Provider. Make a referral to the MMCCM and mail a copy of the verbal COP to the participant/family.

28. What is the difference in the role of the Medicaid Managed Care Case Manager and the EPSDT Support Coordinator (SC)?

The Medicaid Managed Care Case Manager only coordinates medical services whereas the EPSDT SC provides holistic support coordination. The Medicaid Managed Care Case Manager is another resource to assist the EPSDT Support Coordinator with coordinating services.

29. Each MCO has a different timeline so as an SC do I have to remember each timeline and do different PA tracking for each one?

No, you will follow the required actions in LSCIS. You can start a new tracking 60 days prior to the PA end date and you must start a new tracking 20 days prior to the PA end date. Again, LSCIS will keep track of the timelines.

30. For the short-term PA's that some MCO's have, will I have to do a new PA tracking every other month?

Yes, if the PA is more than 30 days long you will be required to complete PA tracking which may mean you are starting a new PA tracking every 60 days. Follow the prompts in LSCIS on the PA tracking log and Tracking Required Action. If you find the PA is issued monthly, you may uncheck PA tracking and provide the valid reason for not tracking and how you'll assure the service is received. This can only be done after you receive the monthly PA and complete the tracking log to show it is issued monthly.

31. How will the SC know which fax number to send the Referral to PAL to?

It is listed on the form.

32. How do SCs assist with finding providers for Medicaid Managed Care members?

There are several avenues. Resources for locating providers contracted with the member's health plan include:

- Online Provider Directory at myplan.healthy.la.gov,
- Call the Member Services Line at each MCO to locate a provider in their network, or
- Access the MCO's websites to identify contracted providers.

PART FIVE – EPSDT SUPPORT COORDINATION REQUIREMENTS

33. For a virtual quarterly visit, can an SC mail the signature page to the family for them to complete during the meeting instead of getting an electronic signature?

According to CMS guidelines, an "electronic signature" for virtual visits can be used, meaning a digital signature that is legally binding and considered equivalent to a handwritten signature, as long as it adheres to HIPAA regulations and ensures proper patient identity verification and security measures are in place; however, CMS does not mandate a specific standard for electronic signatures, leaving it up to the healthcare provider to choose a compliant method.

34. For virtual visits, what does "the provider must agree" mean?

If the family has a provider and they want to invite the provider to the quarterly visit, then the provider must be in agreement that a virtual visit is in the best interest of the beneficiary and technology must be available for all participants.

35. What signatures are required on the CPOC signature page?

Planning Participant's box must have signatures of all Planning Participant's. The participant/guardian must sign and date on the Participant/Guardian's signature line. The Support Coordinator must sign and date on the Support Coordinator's Signature line. The Support Coordinator Supervisor must sign off on the Support Coordinator Supervisor's Signature line after review. The date is the date they completed their review. The information on the paper copy must match the electronic version in LSCIS attached to the CPOC.

36. What are common Quarterly Report deficiencies?

- ❖ Number of trackable service needs does not match the number of service needs being tracked or no documentation submitted.
- ❖ No documentation submitted regarding trackings without a choice of provider (status, any barriers and strategies to remove barriers).
- ❖ Record reviews incomplete. The entire form must be completed as applicable.
- ❖ If there are deficiencies a correction action plan must be completed within 7 days.

Redeterminations

37. An SOA is set to expire during the CPOC year. What do I do?

- ❖ Refer the family to the LGE 60 days before the SOA expiration date. Let the family know that it's time for their redetermination and that they should return any calls or respond to any letters from the LGE to complete the process. Having a current Statement of Approval is required to remain on the DD RFSR, receive a Waiver offer, or have a SUN assessment.

- The SC is not responsible for reminding the LGE that the SOA is expiring; the LGE tracks this. Do not expect the SOA to be completed 60 days prior to the SOA expiration date.
- The SC is responsible for assisting with the redetermination. Please send any current formal documents to the LGE to assist with their redetermination. The SC is also responsible for obtaining the current status of the redetermination and the current SOA from the LGE.
- If the SOA expires, contact the LGE and request the status of the redetermination or a copy of the new SOA. You may need to attach a copy of your Release of Information. Please do this on one e-mail thread and double check the spelling of the beneficiary's name. The LGE has five working days to respond.
- Submit the documentation you obtain from the LGE to Kim Willems at SRI (ksalling@statres.com) to obtain additional prior authorization. SRI will issue an extension if the LGE needs more time. If a new SOA is issued, SRI will issue a full PA.

38. What do I do if a CPOC is due and the Statement of Approval is expired?

Always follow the CPOC due dates on the CPOC Updates Report; do NOT delay submittal because of an expired SOA. Check the Approval/Denial notes on the approved CPOC for more information on the CPOC service dates. SRI can approve the CPOC with the expired SOA. A partial PA will be issued and the PA can be extended with documentation from the LGE regarding the status of the redetermination and their need for more time or the approval for continued services.

39. How long does the LGE (local governing entity) have to complete a redetermination?

We are aware of a backlog of redeterminations at the LGEs. A CPOC can and should be submitted and approved with an expired Statement of Approval as long as the redetermination is in process.

40. What if an SOA does not have an expiration date on the letter?

If the Statement of Approval from the LGE does not have a specific expiration date, it is permanent. Check the Permanent box on Evaluation/Documentation.