

EPSDT – Targeted Population

ANNUAL SUPPORT
COORDINATION TRAINING

Purpose of the Training

This is a **high-level** overview of the EPSDT Support Coordination program and must be used in conjunction with the EPSDT Support Coordination Handbook and Appendices.

We will offer trainings throughout the year that will provide deep dives on each of the three parts we will discuss today.

Current training materials can be found on LDH's website:

<https://ldh.la.gov/page/4981>

EPSDT-Targeted Population Annual Support Coordination Training Module

Overview

Part 1 – Services Available to EPSDT Beneficiaries

Part 2 – Components of Support Coordination

Part 3 – Coordination of Services

What is Louisiana Medicaid?

The Medicaid program provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. The Louisiana Medicaid Program is the “State Plan” and is administered and operated by the Louisiana Department of Health (LDH), according to federal laws and regulations. The Medicaid program is funded by the state and the federal government.

Medicaid is the **payer of last resort**.

Medicaid provides **medically necessary** services.

Beneficiary = an individual who is eligible for and enrolled in the state’s Medicaid program.

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

What is 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.

EPSDT is a legal promise built into Medicaid, designed to ensure children have the opportunity to reach their full health potential – *the right care, to the right child, at the right time, in the right setting.*

What does EPSDT stand for?

Early and Periodic Screening, Diagnostic, and Treatment

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 identifies children's needs by regularly checking in, providing credible screenings, and ensuring timely diagnosis and treatment of problems found.

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. It covers services not available in the State Plan if federally allowed and medically necessary.

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

More detailed info:

- EPSDT-Targeted Support Coordination Training Handbook
- *Appendix D – Services Available to Medicaid Eligible Children Under 21*
- *Appendix E - Medicaid Services Chart.*

What is a Chisholm Class Member?

Chisholm class members (CCM) 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 (DD RFSR).

Chisholm class members choose whether they want to get physical health services through Medicaid Fee-for-Service or through a managed care plan.

What is Support Coordination?

Support Coordination (SC) is a Louisiana Medicaid service that helps beneficiaries access needed supports through structured planning and monitoring. It is provided by agencies under performance agreements with Medicaid and is available through several programs, including EPSDT.

EPSDT SC 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.

SC helps beneficiaries access medical, social, educational, and other necessary services.

✦ **Primary Objective: Help individuals achieve the personal outcomes identified in their Comprehensive Plan of Care (CPOC).**

Who is eligible for EPSDT Support Coordination?

- ✓ Meet Louisiana Medicaid eligibility **AND**
- ✓ Under the age of 21 **AND**
- ✓ On the Developmental Disabilities Request for Services Registry (DD RFSR)

- ✓ **OR** any Medicaid beneficiary ages 3 through 20 for whom support coordination is determined medically necessary (“Special Needs”). Refer to Appendix H – EPSDT SC Fact Sheet.

How does a beneficiary access EPSDT Support Coordination?

Beneficiaries on the Developmental Disabilities Request for Services Registry (DD RFSR) may call SRI toll-free at 1-800-364-7828 or (225)767-0501 and request EPSDT Support Coordination.

If a beneficiary is not yet on the DD RFSR they must contact their Local Governing Entity.

➤ Refer to Appendix [J-1 - LGE Directory](#).

If a beneficiary receives a Statement of Denial from OCDD they may still be eligible for EPSDT SC if they meet the definition of Special Needs. If the beneficiary is no longer eligible to remain on the DD RFSR, they can appeal the notice that is sent out. MPSW will evaluate their eligibility to receive “special needs” support coordination.

➤ Refer to Appendix H - [EPSDT Support Coordination Fact Sheet](#) for full definition.

If a Medicaid beneficiary age 3-20 is not on the DD Request for Services Registry and wants to request “special needs” support coordination, contact MPSW who will evaluate their eligibility.

EPSDT Support Coordination

📞 Key Notes for Families:

- ✓ No cost for EPSDT SC.
- ✓ You keep all your other Medicaid benefits.
- ✓ You choose your provider for each service (Freedom of Choice).
- ✓ You can change Support Coordination agencies if needed.
- ✓ Ending SC does **not** affect eligibility to receive Medicaid services or placement on the DD RFSR.
- ✓ SC is optional.

Goals of Support Coordination

- ✓ Support families in accessing medical, social, educational and other needed supports.
- ✓ Anticipate and identify needs before families request them.
- ✓ Link individuals to services and ensure they're actually received.
- ✓ Streamline care by reducing service gaps and improving communication among providers.
- ✓ Promote the child's health, development and quality of life.

Louisiana Medicaid

Fee-for-Service	Managed Care
FFS = Fee-for-Service, Traditional Medicaid, Legacy Medicaid	MCO = Managed Care Organization (MCO), Healthy Louisiana, Health Plan
State pays providers directly for each service.	Care managed by contracted health plans (Healthy Louisiana)
Any Medicaid-enrolled provider can be used	Must use providers in the MCO's network
State handles all authorizations via their contractor Gainwell Technologies	MCO handles authorizations and care management.

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.

Five managed care organizations (MCOs) working statewide:

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

Voluntary Opt-In and Mandatory Enrollment Groups

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.

- 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.

Voluntary Opt-In and Mandatory Enrollment Groups

Category	Population	Enrollment Type	Notes
Chisholm class member	Beneficiaries under 21, on the DD RFSR	Voluntary Opt-In	May choose: (1) all care through an MCO <u>or</u> (2) only SBHS + transportation through MCO.
Act 421 – Children’s Medicaid Option (TEFRA)	Children under 18 who meet institutional level of care, but whose family income is too high for standard Medicaid.	Mandatory (P-Linkage)	Will receive all Medicaid Covered Services through the MCO (physical, SBHS, transportation)
Coordinated System of Care (CSoC)	Children enrolled in CSoC program.	Mandatory	Receive all CSoC and SBHS through Magellan Health (except PRTF, Therapeutic Group Home, and SUD Residential – those are through MCO). Physical + transportation remain with MCO.
Home and Community Based Waiver (NOW, CC, ROW, SW)	Beneficiaries certified in a home and community based waiver program.	Voluntary Opt-In	May choose: (1) all care through an MCO <u>or</u> (2) only SBHS + transportation through MCO.

Medicaid Eligibility and Enrollment Types

Linkage Type	Meaning	Coverage Arrangement / Prior Authorization Routing
P-Linkage	Managed Care for all covered services.	MCO handles physical health, behavioral health and transportation; prior authorizations routed through MCO .
B-Linkage	Managed Care for behavioral health and transportation only – physical health remains Fee-for-Service	MCO handles behavioral health and transportation; physical health and related PAs go through FFS system, Gainwell Technologies .

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 or visit <https://myplan.healthy.la.gov/en/enroll>.

Tips for Choosing a Health Plan

If the beneficiary wants to keep their doctor, help them make a list of doctors, clinics, hospitals, and other providers they want to keep. Find out which health plans they work with. To find out, use the [Find a Provider](#) page, call the provider, or call Healthy Louisiana.

If the beneficiary wants a new doctor, choose a health plan first. You can see which plans offer services you want on the Compare plans page. All health plans offer the same basic benefits and health management programs. Some offer extra services. See which health plans have programs and services you want, such as:

- Rewards for health living
 - Help to quit smoking
 - Free over-the-counter medications
- SCs should assist with determining if their current providers are in-network. You can search for providers by plan at: MyPlan.healthy.la.gov.
- SCs should provide information on all five plans using Appendix F – MCO Comparison Chart.

Open Enrollment 2025

Members can make changes to their current health plan without a reason between October 15, 2025 and 6 p.m. on December 1, 2025. Changes will take effect January 1, 2026. Changes can be made at myplan.healthy.la.gov, by calling the Healthy Louisiana call center (1-855-229-6848) or using the Healthy Louisiana app.

Members that change their health plan will have from January 1, 2026 to March 31, 2026 (90 days) to change it again.

Louisiana Medicaid Open Enrollment Changes

Louisiana Medicaid is updating the way members choose and change their health and dental plans, giving participants more flexibility and easier access to information.

Beginning March 1, 2026, Medicaid members will be able to switch health or dental plans at any time for any reason. Members can make up to two plan changes within a 12-month period; after that, they must remain in their plan until the next annual period begins.

The first fixed annual period will run from March 1, 2026 to December 31, 2026. Starting in 2027, the annual period will follow the calendar year (January 1–December 31).

Medicaid is changing how it shares enrollment information. Instead of automatically mailing printed materials, information about new enrollment periods will be posted on www.myplan.healthy.la.gov and www.ldh.la.gov. Members who prefer a physical copy can request one by calling 1-855-229-6848. Additional resources, including plan comparison charts, are available online or through the same phone number.

Visit <https://www.myplan.healthy.la.gov/en/changing-your-health-plan-or-your-dental-plan>

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 requests processed on the last business day of the month will be effective on the second following month from the date of request.

Current dates: <https://www.myplan.healthy.la.gov/en>

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.

Medicaid Eligibility Verification

✦ Verify Medicaid eligibility at the beginning of every month using the Medicaid portal or call center and check to see who covers physical and behavioral health for the beneficiary.

- **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.
 - If the beneficiary becomes ineligible for Medicaid, they are no longer eligible for Support Coordination and closure procedures shall be followed.
 - Update the Physical and Behavioral MCO Agency and Medicaid Identification Number (MID) in LSCIS as needed.
- Refer to section 4.2.2 Health Benefit Plan Coverage for different cases and how they're depicted in the eMEVS response. The user manual for eMEVS can be found here:
<https://www.lamedicaid.com/provweb1/forms/UserGuides/MEVSHelp.pdf>.
- 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.

Address Changes

Be sure to keep the beneficiaries contact information up to date. Medicaid needs the beneficiaries current address, phone number, cell phone number, and email. If Medicaid doesn't have current contact information, the beneficiary could miss important letters and risk losing health coverage.

If a beneficiary needs to report an address change, have the beneficiary or legal guardian:

1. Log into their account at [MyMedicaid.la.gov](https://www.MyMedicaid.la.gov). If they do not have an online account, they can create an account at any time. Creating an online account allows the beneficiary to check the status of their application, report any household changes, report an address change, request a replacement Medicaid ID card, and renew their Medicaid benefits.
2. E-mail MyMedicaid@la.gov.
3. Call Medicaid Customer Service toll free at 1-888-342-6207.
4. Call their health plan at the Member Services Line.

What is Prior Authorization?

PA = prior authorization or pre-approval; provider must get approval from the beneficiary's health insurance before services begin.

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

Decisions: Approved, Denied, or More Info Needed.

📞 Families should understand: PA is not optional – it's the green light to start services.

Who Covers What?

Service Category	P-Linkage (MCO covers all)	B-Linkage (Split coverage- FFS for P and MCO for B)
Physical Health Services	MCO	FFS via FI/Gainwell Technologies
Specialized Behavioral Health Services (SBHS)	MCO	MCO
Transportation Services	MCO	MCO
Applied Behavioral Analysis (ABA)	MCO	MCO
Carved Out Services	Not covered by MCOs and must still be accessed through FFS.	Not covered by MCOs and must still be accessed through FFS.

Carved Out Services

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

- Coordinated System of Care (CSoC) – contact Magellan at 1-800-424-4489
- IEP services provided by a school district
- Home & Community-Based Waiver Services (except 1915(b) mandatory enrollment waiver, 1915(c) SED waivers, and 1915(i)SPA services) – contact OCDD at 1-866-783-5553
- Targeted Case Management Services
- Medical Dental with the exception of the EPSDT varnishes provided in a primary care setting – contact MCNA or DentaQuest
- Long Term Nursing facility services – Contact Louisiana Options in Long Term Care at 1-877-456-1146

MCO members are eligible for Carved Out Services. However, the MCO will not pay for these services. Louisiana Medicaid will, through Fee-for-Service.

Part 1

SERVICES AVAILABLE TO
EPSDT BENEFICIARIES

Medicaid Services Available to EPSDT Beneficiaries

- ✓ **ALL medically necessary Medicaid services** that are available to individuals under the age of 21
- ✓ physical health services
- ✓ specialized behavioral health services
- ✓ transportation
- ✓ school-based services
- ✓ developmental disability services

EPSDT Screening Exams and Checkups

Eligibility: All beneficiaries under age 21. Preventative well-child benefit.

Coverage Requirements: Covers comprehensive health, dental, vision, hearing, developmental, and behavioral checks. Includes diagnosis and treatment of identified needs, even if not normally in the State plan. Available on a periodic and interperiodic basis.

SC Role:

- Educate families on the importance of regular screenings.
- Ensure screenings are **on schedule** (check visit history).
- Assist in scheduling medical, dental, vision and hearing appointments and transportation.
- Document screenings in the CPOC and follow up on referrals made after screenings.

EPSDT Screening Exams and Checkups

Communication Tips:

- Encourage families to keep copies of screening reports.
 - Remind them that missing screenings may delay access to other services.
 - Clarify that EPSDT covers **treatment** of identified needs, not just the screening itself.
- Refer to Louisiana Medicaid periodicity schedule for recommended intervals.
- An **interperiodic screen** can be obtained whenever one is requested by the parent or is recommended by a health, developmental, or educational professional - including an SC - in order to determine a child's need for health treatment or additional services.
- 📌 You may obtain an appointment for a screening visit by contacting the beneficiary's primary healthcare provider.

EPSDT Personal Care Services (PCS)

Eligibility: Beneficiaries under age 21 needing help with activities of daily living due to a medical condition.

Coverage Requirements: Must be medically necessary, age appropriate and prescribed by a practitioner. Requires prior authorization by FI/MCO. Provided at home or medically necessary location.

What's Covered:

- ✓ Personal care: toileting, grooming, bathing, dressing
- ✓ Mobility: bed mobility, transfers, walking assistance
- ✓ Eating: help with eating, meal prep for beneficiary only
- ✓ Incidental cleaning related to care tasks
- ✓ Accompanying (not transporting) to medical appointments

What's NOT Covered:

- × Medical tasks (nursing, tube feeding, medication administration, etc.)
 - The EPSDT PCS program, by definition, does not include any medical tasks such as medication administration, tracheostomy care, feeding tubes, catheters, or skilled nursing services. If such tasks are necessary, they must be requested under the Home Health program. Refer to *Appendix G – EPSDT PCS vs. Home Health and PCS Rule Information*.
- × Transportation
- × Childcare or respite care

EPSDT Personal Care Services (PCS)

SC Role:

- Identify need during assessment.
- Ensure practitioner has all relevant info (typical weekly schedule, needs list, etc.).
- Help family find a willing provider. If unable to locate a willing provider, SC must report difficulties to PAL. LDH or MCO must take all reasonable and necessary steps to locate a willing and able provider within ten days. “Able” means the provider has staff available to provided the need care on a regular basis.
- Ensure forms and PA requests are complete and submitted timely.
- Follow-up until services start; monitor quality and appropriateness.
- Coordinating schedules

EPSDT Personal Care Services (PCS)

Communication Tips:

- No set limit on PCS hours - based solely on documented needs.
- Parent/caregiver does not have to be home while services are being provided.
- PCS does not replace parental care responsibilities; not used for respite.
- Hours cannot be “saved” or “rolled over.”
- Immediate family cannot be the direct support worker (DSW).
- Do not have to have SC to receive PCS.

EPSDT Personal Care Services (PCS)

Quick Steps to Get PCS

1. Talk to practitioner - get form 90, order, and medical records to support the request.
2. Choose an in-network PCS provider agency.
3. Agency submits PA request (with Medicaid card, order, form 90, plan of care, social assessment, daily schedule, and documentation to support the medical necessity of the request).
4. FI/MCO reviews PA for medical necessity.

Refer to:

- Appendix G - [EPSDT Personal Care Services vs. Home Health and PCS Rule Information](#)
- Appendix BB-7 – [EPSDT-PCS FAQ and Guide to Provider Locator Tools](#)

Extended Home Health Services

Eligibility: Beneficiaries under age 21 who are considered “medically fragile.”

Coverage Requirements: Services must be medically necessary and prior authorized.

SC Role:

- Obtain a prescription stating the number of hours requested and a letter of medical necessity justifying the reason for extended skilled nursing services.
- If unable to locate a willing provider, SC must report difficulties to PAL. PAL must take all reasonable and necessary steps to locate a willing and able provider within ten days. “Able” means the provider has staff available to provided the need care on a regular basis.
- Coordinate schedules.

Communication Tips:

- EHH often supports medically fragile children at home.

Refer to Appendix G - [EPSDT Personal Care Services vs. Home Health and PCS Rule Information](#)

Other Home Health Services

Skilled Nursing (Intermittent or part-time)

- Refers to less than three hours of nursing care per day; must be prescribed by an authorizing healthcare provider and can be obtained without prior authorization.
- Note: Adults over age 21 are limited to 50 visits per year. Numerical limits do **not** exist for EPSDT recipients (Medicaid recipients under age 21).

Home Health Aide Service

- Provided in accordance with the home health plan of care as recommended by an authorizing healthcare provider.
- FFS: Home health aide services must be prior authorized; MCO: check with the MCO.

Rehabilitation Services

- Physical, occupational and speech therapies, including audiology services that can be provided in the home by a home health agency.
- FFS: All rehabilitation services must be prior authorized; MCO: check with the MCO.

EPSDT PCS vs. EHH

Service Type	Purpose	Who Provides It	Key Indicators	Examples
EPSDT Personal Care Services (PCS)	Help with activities of daily living	Direct service workers	Needs help with basic daily needs	Eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements.
Extended Home Health (EHH)	Skilled nursing care in the home	Licensed nurses or therapists	Medically fragile children that need more than 3 hours/day of nursing care	Tube feedings, wound care, medication administration, monitoring complex medical conditions
Both	Recipient has daily care needs and skilled needs	Aides and nurses/therapists	Daily living support + ongoing medical interventions	Child with complex medical condition needing daily bathing & transfers plus trach care

Refer to Appendix G – EPSDT PCS vs. EHH

EPSDT PCS vs. EHH

SC Role:

- Assess daily living needs and medical/skilled needs through interviews and documentation review
- Collaborate with the PCP and providers to confirm medical necessity
- Ensure the right combination of services is authorized – sometimes both are need to fully meet the beneficiary's needs
- Document how each service addresses aspects of their care

Pediatric Day Health Care (PDHC)

Eligibility: Medically fragile beneficiaries under age 21, including technology dependent children, who require close supervision.

Coverage Requirements: services include skilled nursing, therapies, assistance with ADLs, and transportation to/from PDHC. 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. Must be prior authorized by FI/MCO.

SC Role:

- Assist with collecting medical documentation and PA.
- Coordinate schedules.

Communication Tips:

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

Therapy Services

Eligibility: beneficiaries under age 21 with medical need for therapy.

Coverage Requirements: Services include: 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**, you must have a physician order and a licensed therapist evaluation.

- Periodic re-evaluations are needed.
- **FFS:** PA required; **MCO:** check with MCO on PA requirements.

Therapy Services

SC Role:

- Ensure evaluations support PA requests.
- Coordinate therapy schedules with other services the beneficiary is receiving.
- Help the family to determine the setting in which the child will receive the greatest benefit.

Communication Tips:

- Remind about attendance to avoid PA denial.
- Ask if they want to receive therapies outside of the school setting, **in addition** to those they receive in school.
- Ask if they want to receive therapies during the school's summer break.

Medical Equipment and Supplies

Eligibility: beneficiaries under age 21 with a medical need.

Coverage Requirements: Beneficiaries are entitled to **any medically necessary equipment or supplies** needed to correct, improve, or assist in dealing with physical or mental conditions. This includes:

- wheelchairs, lifts and other devices to help the family deal with a child's circumstances such as communication devices,
- dietary or nutritional assistance,
- disposable incontinence supplies (diapers, pull-on briefs, and liners/guards) for children ages 4 – 20.
- Must be prescribed by a physician.
- **FFS:** PA required; **MCO:** check with the MCO to determine if the MCO requires PA.

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

Medical Equipment and Supplies

SC Role:

- Proactively investigate whether equipment would ease the child's needs.
- Assist families by arranging for prescriptions and connecting with providers when necessary.

Communication Tips:

- Ask about the child's daily challenges so equipment needs are explained in family terms.

Medical Equipment and Supplies

If the requested item is denied, Medicaid FFS/MCO may offer a less costly alternative.

SC Role:

- 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.
- Explain appeal rights to the family and assist in the appeal if the beneficiary wants that help.

Note: 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.

Services for Beneficiaries with Autism or Related Disorders

For every Chisholm class member that has an Autism diagnosis or a related disorder or has even been labeled, even informally, as having Autism or a related disorder, please make sure you are either:

- connecting the class member with Applied Behavioral Analysis (ABA), or
- 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.

ABA services are 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 the SC fails to identify ABA as a possible therapy and arrange for it unless declined.

Clinical Diagnostic Evals

What is a Clinical Diagnostic Eval?

- To receive ABA, the beneficiary must first be evaluated by a qualified health care professional. The evaluation is called a CDE, for Comprehensive Diagnostic Evaluation. After evaluating the beneficiary, the health care professional will prepare a report explaining why the beneficiary does or does not need ABA services.

How to obtain the CDE

- Complete a referral to the MCO for a CDE. MCOs are responsible for arranging CDEs that are requested. CDE's do not require prior approval. SCs must follow-up as needed to ensure MCO's arrange for CDE's.

SC role

- try to collect a CDE if one was already done.
- refer for a CDE if not already done and help the beneficiary find a willing CDE provider.
- collect records for the QHCP if needed.
- report delays or difficulties locating a willing provider to the PAL.
- follow-up to ensure the CDE is scheduled, completed and obtain a copy of the CDE.
- If ABA is recommended, discuss with the family and refer to ABA as requested.

Applied Behavioral Analysis (ABA)

Eligibility: Beneficiaries under age 21 with a qualifying diagnosis (e.g. Autism spectrum disorder or a related disorder).

Coverage Requirements: must be medically necessary, prior authorized by the MCO, and provided by a Medicaid-enrolled, licensed behavior analyst with an appropriate treatment plan.

SC Role:

- Assist with gathering clinical documentation, facilitating PA submissions, and tracking the PA.
- Collaborate with MCOs.

Communication Tips:

- Keep families informed – explain eligibility, provider options, and next steps.
- ABA is most effective when delivered as early as possible in the child's life (ages 2 – 6).

Transportation Services

Eligibility: all beneficiaries who need a ride to healthcare services.

Coverage Requirements:

- **NEMT** (Non-Emergency Medical Transportation): rides to appointments for ambulatory or wheelchair users;
- **NEAT** (Non-Emergency Ambulance Transportation): for medically fragile children who cannot use regular transport;
- **Gas Reimbursement:** family/friends may be reimbursed for driving.

SC Role:

- Assist with scheduling transportation.
- Ensure transportation services are in the CPOC when travel is a barrier to care.
- Track missed appointments and troubleshoot quickly.

Communication Tips:

- Keep provider phone numbers handy.
- Schedule rides 48-72 hours (excluding Saturdays, Sundays and legal holidays) in advance.
- Remind families they must be ready at the scheduled pickup time.

Coordinated System of Care (CSoC)

Eligibility: Children ages 5-20 with significant behavioral health challenges at risk of out-of-home placement with significant behavioral health needs.

Coverage Requirements: administered by Magellan Health (not the MCO). Requires CSOC screening and approval. Services include: Wraparound Facilitation, Parent Support and Training, Youth Support and Training, Short Term Respite Care, and Independent Living and Skills Building.

SC Role:

- Identify and refer youth who may meet CSOC criteria.
- Collaborate with the Wraparound Facilitator once enrolled.
- Ensure CSOC services are integrated into the CPOC.
- Coordinate with Magellan for any services updates or crisis planning needs.

Communication Tips:

- Explain CSOC is separate from their MCO but still Medicaid-covered.
- Provide Magellan's contact information and referral process.
- Emphasize the programs' goal: keep the child at home or in the least restrictive environment possible.

Specialized Behavioral Health Services (SBHS)

Eligibility: Beneficiaries under age 21 who meet medical necessity criteria.

Coverage Requirements: covered through the MCO for most members. May require assessment + prior authorization.

- Outpatient therapy (individual, group or family)
- Psychiatric services and medication management
- Crisis intervention and stabilization
- Rehabilitation services (skills training, psychosocial rehab)

SC Role:

- Link families with MCO behavioral health providers or specialty networks.
- Ensure assessments and treatment plans are current.
- Include behavioral health services and goals in the CPOC.

Communication Tips:

- Share MCO behavioral health provider directories with families.
- Remind families to attend scheduled appointments to avoid gaps in care.
- Promote use of crisis line or the MCO 24/7 nurse lines when needed.

School-Based Behavioral Health Services

Eligibility: Medicaid-enrolled students who need behavioral health support in participating schools.

Coverage Requirements: Provided by Medicaid-enrolled behavioral health providers contracted with the school. Covered under the member's MCO. Requires a behavioral health assessment and treatment plan. May include Individual/group/family therapy, skills training and psychosocial rehab, crisis intervention.

SC Role:

- Confirm the child's school offers school-based behavioral health services.
- Assist family with consent forms and connection to provider.
- Ensure services are reflected in the CPOC alongside out-of-school supports.
- Monitor service delivery and follow up on concerns.

Communication Tips:

- Explain school-based care does not replace outpatient/home therapy. Services provided in the school are to improve a child's ability to receive their education; services provided outside of school can have broader goals.
- Maintain open communication with families and schools.
- Clarify referral and consent process.

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 1-888-758-2220.
- 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 are supports and resources not covered by Louisiana Medicaid but that can help meet a child's medical, social, educational and developmental needs.

SCs help individuals gain access to the full range of needed services.

SCs are NOT limited to Medicaid-related services – they are responsible for facilitating access across a broad array of service types, many of which fall outside Medicaid.

Non-Medicaid Services

OCDD Local Governing Entities (LGE)

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

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*.

Non-Medicaid 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 through School Systems section.

Other community services

- SCAs must maintain a current resource directory of formal and informal service providers. It must be updated regularly and SCAs must ensure SCs use it to link individuals with appropriate 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).

The DD RFSR is arranged by urgency of need and date of application for developmentally disabled waiver services. The tool known as the Screening for Urgency of Need (SUN), was designed to identify any needs a person may have, review current supports a person has and uses now, and determine the urgency of any unmet needs the person has.

To find the beneficiary's SUN score or to request a rescreening due to a change in status, call the LGE.

To update the beneficiary's contact information on the DD RFSR, call the LGE.

➤ Refer to Appendix [J-1 - LGE Directory](#)

Home and Community Based Waivers for People with Developmental Disabilities

Children's Choice Waiver (CC) – offers supplemental support to children birth through age 20 who currently live at home with their families or with a foster family.

Supports Waiver (SW) – offers focused, individualized vocational services to people over the age of 18 who otherwise would require the level of care of an intermediate care facility.

Residential Options Waiver (ROW) – offers people of all ages services designed to support them to move from ICFs/DD and nursing facilities to community-based settings, and to serve as an alternative to institutionalization.

New Opportunities Waiver (NOW) – offers people ages three and older, who require intermediate care facility services, to remain in their communities.

➤ Refer to Appendix I - [Waiver Fact Sheets \(CC, SW, ROW, NOW\)](#)

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. Non-Waiver Medicaid services do not count against the \$20,650 cap.

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.

EPSDT Age Out

Once a beneficiary turns 21 years old, they “age out” and are no longer eligible for EPSDT-specific services like support coordination, EPSDT Personal Care Services, extended home health, and incontinence supplies. Some services remain covered, but others may be limited or require extra steps.

- **Dental Care:** routine dental and tooth repairs to natural teeth may no longer be covered. Encourage beneficiary to be up-to-date on dental appointments. May need to switch to an adult provider. Refer to Appendix F - MCO Comparison Chart for additional information on Adult dental (21+).
- **Vision:** items like glasses may no longer be covered or require additional documentation. Encourage beneficiary to be up-to-date on all vision appointments.

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.

Chisholm class members that are in fee-for-service for physical health will need to select a MCO.

EPSDT Age Out

SC Role:

- Planning should begin well in advance and must begin at least 6 months prior to the beneficiary's 21st birthday.
- Inform of change in Medicaid Services for adults.
- 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.
- Review adult plan benefits with beneficiaries and confirm coverage details.
- Identify adult providers and coordinate appointments, transfer medical records, and connect families with new health care providers.
- 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 CPOC:** 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.

EPSDT Age Out

Available services for adults 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. Referrals to LRS can be made beginning at age 16.**
- **OAAS Community Choices Waiver and Adult Day Health Care Waiver services** – Only beneficiaries without a Statement of Approval for Developmental Disability services through OCDD can be added to the OAAS waiting lists. Since Chisholm class members by definition will have a Statement of Approval for DD services, they are excluded from receiving these services. However, beneficiaries who receive Special Needs Support Coordination (see p. 36 and Appendix H) can be added to OAAS waiting lists. Call Louisiana Options in Long-Term Care at 1-877-456-1146 (TTY 1-855-296-0226) to be placed on a waiting list.

EPSDT Age Out

For more information please visit:

- **EPSDT Age Out:** <https://ldh.la.gov/medicaid/epsdt-age-out>
- **A Guide to Aging Out of EPSDT (Children's) Benefits for Medicaid Members Turning 21:** https://ldh.la.gov/assets/medicaid/Memos/EPSDT_AgeOut.pdf
- **Medicaid Services Chart:**
<https://ldh.la.gov/assets/medicaid/MedicaidServicesChart.pdf>

➤ **MCO Comparison Charts:**

Medical - https://myplan.healthy.la.gov/content/dam/digital/united-states/louisiana/la-eb/language-masters/en/pdf/LAEB-HP-COMP-E_17ag%20051724.pdf

Dental - <https://myplan.healthy.la.gov/content/dam/digital/united-states/louisiana/la-eb/language-masters/en/pdf/LAEB%20DentalCompChart%20ENG%20v27ag%20%20053024.pdf>

Part 2

COMPONENTS OF SUPPORT COORDINATION

Components of SC

Intake – determine if the individual accepts SC and agrees with contact requirements.

Assessment & Reassessment – Initial, quarterly (or as needed), and Annual reviews of needs

CPOC – person-centered, developed with support team

Service Referrals & Linkage – connecting to services

Ongoing Monitoring & Advocacy – ensure services are delivered; goals reviewed at least quarterly

Intake

- Contact within 3 business days of linkage; in-home meeting within 10 calendar days.
- Verify Medicaid eligibility.
- Gather formal documents including SOA.
- Face-to-face (in-person) meeting: explain services, rights, responsibilities and how SC can help.

Competent Majors

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.

Assessment & Reassessment

Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services.

Assessment activities include:

- Taking client history
- Identifying the beneficiary's needs and completing related documentation
- 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.

Formal Documents

Obtain:

- assessments/evaluations and documents OCDD used to determine eligibility,
 - current IEP (if receiving Special Education),
 - current Home Health Plan of Care (if receiving EHH),
 - current Pediatric Day Healthcare Plan of Care (if receiving PDHC), and
 - any other assessments by professionals (EPSDT-PCS Form 90, LRS and Special Education Evaluations, behavior plans, psychological and other evaluations, etc.)
- 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.
 - Assist with arranging professional evaluations and appointments.

!! A form 90 is **not** required to obtain CPOC approval. It can be used as a formal document if the beneficiary is not receiving Special Ed, EHH or PDHC.

 **Current** = less than a year old at time of CPOC meeting.

CPOC

- Developed through a person-centered planning process with the beneficiary, guardian, and support team.
- Includes personal outcomes, goals, strategies, and timelines.
- Covers medical, educational, behavioral, and social needs.
- Identifies a course of action to respond to assessed needs.
- Must be signed by all planning participants & entered into LSCIS.
- Revised annually and as needed; reviewed at least quarterly.

The SC is responsible for coordinating services identified in the CPOC **immediately** upon completion of the CPOC and prior to approval from SRI. Approval of the CPOC only controls payment to SCAs. The CPOC does not control the services.

Core Responsibilities

Monthly Contact: check on services, satisfaction, and needs.

As-Needed Contact: support until all services are in place (actually being received).

Quarterly Review: Assess service status and satisfaction. Use the EPSDT CPOC Quarterly Review/Checklist and Progress Summary in LSCIS.

Monitoring & Follow-Up: confirm services match needs; adjust when necessary.

Meeting Requirements

- Beneficiary and Guardian must be present for initial, quarterly, and annual meetings.
- Initial and Annual CPOC meetings must be held in-person in the beneficiaries home.
- Quarterly Visits can be held at location of beneficiary choosing. Telehealth visits are allowed (maximum of two telehealth per year; must meet virtual visit criteria; must hold at least one quarterly in-person per year; must not be Initial/Annual CPOC meeting.)

Addressing Issues

SCs help resolve provider dissatisfaction or complaints.

Use proper complaint forms.

- Appendix Q - [Complaint Form](#)
- Appendix R - [Managed Care Complaints](#)

Adjust CPOC when needs, status, or provider issues arise.

Escalate unresolved issues to PAL or SRI.

Closures

- Waiver Transition: remain open until the Waiver is certified; EPSDT PA will be pulled back to the day before the certification date.
 - Use “change in target population” when Waiver is certified.
 - Use “refused services” if family declines EPSDT SC while waiting for Waiver to be certified.
- Initials: If no face-to-face assessment occurred and no PA was issued, closure requires contacting the EPSDT SC Contractor first and including documentation to support the closure.
- Medicaid Ineligibility: the SC must notify the beneficiary/family immediately and close. Advise family how to reopen if Medicaid is reinstated.

Closures

- Closure decisions should be reached with the full participation of the beneficiary/family when possible.
- Always inform beneficiary that they can contact SRI to resume services, and provide the toll-free number 800-364-7828.
- Cases may be reopened by SCA within 6 months of case closure. If more than 6 months since case closure, beneficiary must call SRI to receive a new linkage.
- Declining EPSDT SC has no impact on eligibility to receive Medicaid services or placement on DD RFSR.

Transfers

- Receiving Agency: receives linkage from SRI and requests transfer of records from Transferring SCA. Complete Intake and schedule face-to-face visit.
- Transferring Agency: forward records promptly to new SCA. Submit closure in LSCIS (reason = transferred).
- The Receiving Agency must submit the completed Transfer of Records to EPSDT SC Contractor to transfer the LSCIS CPOC(s) and the Support Coordination PA. CPOC dates will not change. (Completed = signatures of Transferring & Receiving Agency).
- The PA for the Receiving Agency will begin on the first day of the month following the Receiving Agency signature date.

Documentation & Compliance

If it's not documented, it didn't happen.

Log everything in LSCIS Service Logs - activities, contacts, attempted contacts, PA Tracking, etc. Service logs must provide a narrative.

Keep original signature pages on file.

Save your receipts - e-mails, fax confirmations, referrals, whatever proves you did the thing.

Documentation proves that Chisholm protocols and procedures were followed.

Quarterly Report

Quarterly Report is due **every** January 5th, April 5th, July 5th, October 5th. Set your reminders!

- Enter all PA info and service logs prior to the end of the quarter.
- Number of trackable services needs must = number of service needs being tracked.
- Trackings without COP (choice of provider)- submit documentation and explanation
- PA not Issued within 60 days – One Appendix W-3 Record Review for each
- Gap in PA Period – One Appendix W-4 Record Review for each
- If deficiencies were found in required contacts, timelines, follow up, documentation, etc. the agency will submit a Corrective Action Plan (CAP) within 7 days and documentation that the CAP was carried out within 14 days.

Training & Oversight

All EPSDT SCs, supervisors and trainers must complete Annual EPSDT Training.

New staff must be trained before taking on caseloads.

Submit documentation of training to the EPSDT SC Contractor, SRI, using Appendix W-4 – Training Log.

On-Site Program Manager and EPSDT Specialist must ensure compliance with all program requirements. Review reports at least twice a week and resolve deficiencies.

Caseload size = maximum of 35 cases.

Part 3

COORDINATION OF SERVICES



Linking & Monitoring Services

- Offer services when you see a need (do not wait for the family to request it).
- Document offer and response (requested, declined, on hold).
- Suggest appropriate evaluations if service needs are unclear.
- Coordinate across Medicaid, school and community systems.
- Track the status of prior authorization requests.
- Inform the PAL of providers who are not actively developing requests.
- Inform beneficiaries they may choose another provider and assist in locating available providers.
- Assist in assembling documentation to support requests.
- Close the loop – ensure services are actually received/delivered.

Referrals to Services

SC Role: Identify the need and make a referral to a provider or program.

Referral = connecting the beneficiary to medical, social, educational, or community providers that are **capable** of providing needed services to address identified needs and achieve goals specified in the CPOC.

Linking to Services

SC Role: Help the family actually receive the service, ensuring the referral is successful.

Linkage = ensuring the beneficiary has access to and is **actually receiving** the most appropriate services as defined in their CPOC.

Reminder: Linkage is a **proactive**, not passive – SCs should anticipate needs, actively engage networks, help locate resources and advocate when necessary to ensure services are truly delivered.

Navigating the System

- Know the right contacts at LDH, MCO and provider agencies.
- Understand PA rules and timelines.
- Assist with appeals and renewals to avoid gaps in care.
- Maintain and use an updated resource directory.
- Reduce stress for families – handle paperwork, track timelines, and keep communication clear.
- Keep logs/notes of every step so nothing slips through the cracks.

SCs know how to work the system – tracking timelines, chasing paperwork, linking providers, and pushing the process forward so the family doesn't get stuck.

Coordinating PAed Services

- ✓ Identify the service need.
- ✓ Track status in LSCIS and follow up promptly.
- ✓ Gather all required documentation.
- ✓ Offer a full list of possible providers for the services, also known as Freedom of Choice (FOC).
- ✓ Locate willing providers.
- ✓ Ensure PA requests are submitted timely with complete forms to avoid delays or gaps.
- ✓ Communicate with the PAL.
- ✓ Follow through with requests until PA is approved or denied based on medical necessity.
- ✓ Assist with appeals.
- ✓ Close the loop: make sure services actually start after approval.
- ☎ Communicate with families in plain language and keep them informed (explain what's happening).

Gathering & Submitting Documentation

- Provide specific medical forms needed.
- Collect medical records, prescriptions and evaluations from providers.
- Offer scheduling and transportation assistance.
- Make sure forms are complete, signed, and submitted on time (avoiding denials due to missing info).
- Log and track all activities.
- Keep families informed and updated at every step.

Locating Providers

Verify Medicaid eligibility at the beginning of every month and check to see who covers physical and behavioral health for the beneficiary.

Tools for Locating Providers:

- Appendix X-1 - [Contact Info for EPSDT SCA](#)
- Appendix X-2 - [MCO Contacts for EPSDT SCA](#)
- Appendix BB-7 – [EPSDT-PCS FAQ and Guide to Provider Locator Tools](#)

Freedom of Choice: Provide a **current** list of agencies in the beneficiary's network. Beneficiary selects their preferred provider.

SC Role:

- Help **contact prospective providers.**
- Confirm their willingness to submit PA request for beneficiary.
- Ensure provider can deliver services once approved.

Prior Authorization Liaison (PAL)

- Facilitates the PA approval process for Chisholm class members and assists with problems on PA requests so that a decision is rendered as to medical necessity.
- Ensures SCs are notified of requests (approved, denied, reduction in services, requests for additional information), status and any delays to the PA approval process.
- Makes every effort to obtain PCS and EHH services within 10 days when there have been problems. MCO PAL reports to Chisholm compliance team if MCO has not located a provider within 10 days of SC report to the MCO PAL.

SC Role:

- Communicate promptly with PAL
- Help gather any additional documentation needed
- Notify LDH PAL when a PA tracking log that had a Referral to PAL sent is closed and explain why. This allows LDH staff to focus on active PAL Referrals.

Appeals

- 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.

If services are denied explain appeal rights, provide appeal brochure, and assist if requested.

- **FFS:** appeal to DAL;
- **MCO:** appeal at MCO level first, then DAL State Fair Hearing if needed.

Refer to:

- Appendix P - [Appeal Brochure](#)
- Appendix AA-2 - [PA Tracking](#)

Appeals

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.

MCO Appeals

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 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.

Renewals

Renewals: ensure there is no gap in services.

1. Open a Renewal tracking log. (**FFS** = 45-60 days before expiration; **MCO** = 20-60 days before expiration)
 - Date of Service Request = same as previous log.
 - Date of COP (choice of provider) = new date; date you confirmed beneficiary wants to stay with current provider.
2. Send Referral to Provider - #3.
3. Enter date you sent Referral on both tracking logs.
 - Previous Tracking Log = Date Renewal Sent and new tracking started
 - Renewal Tracking Log = Date Referral to Provider

Ⓜ If previous PA expires and you do not have a Renewal PA on file, send a Referral to PAL - #3.

Barriers & Problem Solving

Waitlist Placement:

- Confirm waitlist placement with provider.
- Offer alternative providers.
- Notify the PAL – Referral to PAL - #5
- Follow up with provider on waitlist placement every month.

If no provider is available:

- FFS: SC must call LDH Program Staff Line.
- MCO: SC must call Member Service Line.
- Notify the PAL – Referral to PAL - #4
- LDH/MCO will take all reasonable steps to locate a willing and able provider within 10 days.

If provider lacks staff :

- Notify the PAL – Referral to PAL - #7
- Offer FOC.
- LDH/MCO will take all reasonable steps to locate a willing and able provider within 10 days.

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

Referrals to PAL

- ✓ Complete the form in its entirety and check for misspellings.
- ✓ Send to the correct PAL.
- ✓ Attach the EPSDT Prior Authorization Tracking Log(s), all Referrals, e-mails and supporting Service Logs that document the contacts made regarding the issues identified on the form.
- ✓ The PAL should be able to follow up on the issue without needing to contact you for more information.
- ✓ Show your work. What did you do to try to resolve the issue before notifying the PAL?

Coordinating Services

- Typical Weekly Schedule - the weekly schedule should indicate what services are already in place and the services that are being requested through Medicaid prior authorization or other sources. The schedule should show when the participant is in school, at home or participating in other activities.
- The Typical Weekly Schedule should be revised to reflect any changes.
- SCs must ensure that in-home services (PCS, home health, hospice, therapists) do not overlap unless medically necessary. BHSF or its designee will determine medical necessity for FFS beneficiaries; the MCO will determine medical necessity for beneficiaries in managed care.

Continuity of Services

- **Monitor services regularly**
 - Ensure services are delivered as authorized in the CPOC
 - Check for missed visits, provider changes, or schedule disruptions
- **Address gaps immediately**
 - Communicate with the beneficiary/family and providers to identify the issue
 - Document actions taken in service logs and/or tracking logs
 - Follow-up until the service resumes or is formally modified
- **Plan ahead for transitions**
 - Review upcoming CPOC expirations, SOA expirations, IEP due dates or age-related changes
 - Start Renewals on time to prevent lapses
- **Coordinate across systems**
 - Maintain regular contact with medical providers, schools and community agencies.
 - Facilitate referrals and linkages to cover gaps
- **Notify and Advocate**
 - Inform families of changes and their options
 - Advocate for expedited approvals when delays occur

Key Takeaways

SCs ensure: right care, right child,
right time, right setting.

Be proactive, organized and family-centered.

Always document, follow up and advocate until
services are in place.

Questions/Comments

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

SRI Contact Info

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Next Up

- Competency Test
- Individualized Training with review of LSCIS including Reports, feedback on deficiencies, real world examples.