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 EPDST – 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

- EPSDT – Targeted Population Support Coordination Training Handbook & Appendices
  - An electronic copy of the Handbook has been given to each agency. 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.
- EPSDT Training Module –
  - Part 1 – EPSDT-Targeted Population
    - Services Available to EPSDT Beneficiaries
    - Intake, Assessment and CPOC
    - Coordination of Services
    - Other Requirements
  - Part 2 - Medicaid Managed Care Program
  - Part 3 - COVID-19 Exceptions

Part 1

EPSDT-Targeted Population

EPSDT

- **E**arly: Assessing and identifying problems early
- **P**eriodic: Checking children's health at periodic, age-appropriate intervals
- **S**creening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **D**iagnostic: Performing diagnostic tests to follow up when a risk is identified, and
- **T**reatment: Control, correct or reduce health problems found.

EPSDT – Targeted Population Support Coordination

- This program was established as a result of a lawsuit (Chisholm v. LDH) to provide Support Coordination to those individuals who have disabilities and/or chronic health conditions.

EPSDT 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.

Chisholm Class Members

- Chisholm class members are children under the age of 21 who currently receive or are eligible for Medicaid, and who are on the Developmental Disabilities Request for Services Registry (DD RFSR).

Legacy Medicaid and Medicaid Managed Care Program

- **Legacy Medicaid (Fee for Service)**
  - This is traditional Medicaid for people who are not enrolled in a Managed Care Organization (MCO) for most of their health services. Chisholm class members have the option of staying in Legacy Medicaid for their physical health services.
- **Medicaid Managed Care Program (MMC)**
  - Healthy Louisiana is the way most of Louisiana's Medicaid beneficiaries receive health care services. The state contracts with Managed Care Organizations (MCO) that deliver these services through their provider networks. Some of these MCOs have a different network of doctors, hospitals, and other providers than traditional Medicaid.
  - Some Medicaid beneficiaries only receive specialized behavioral health services and transportation services through their Health Plan.
  - Chisholm class members may choose to have all of their health care through the Health Plan or only their specialized behavioral health services. This is call "opt-in."
  - Coordinated System of Care (CSoC) Waiver recipients will access most of their specialized behavioral health services and CSoC services through Magellan.

Services Available to EPSDT Beneficiaries

Services Available to EPSDT Beneficiaries

- Children and youths receiving targeted EPSDT Support Coordination are eligible to receive all medically necessary **Medicaid services** that are available to people under the age of 21.
- 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 the Office for Citizens with Developmental Disabilities (OCDD) through the Local Governing Entities (LGE).
- Services through the **Office of Behavioral Health** (OBH) are available for children and youth with emotional disturbances.
- Children and youth may be able to receive services through the **school system** or through Early Childhood Education programs.

Medicaid Services Available to EPSDT Beneficiaries

- Through Medicaid, children under the age of 21 are entitled to receive **all medically necessary** health care, diagnostic services and treatment, and other measures coverable by Medicaid to correct or improve physical or mental conditions, even if these are not normally covered by Medicaid for beneficiaries ages 21 or older.
- 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 any restrictions allowable under federal Medicaid law.
- Refer to *Appendix F* for an expanded list of services available to Medicaid eligible children under the age of 21.

Medicaid Services Available to EPSDT Beneficiaries

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)

Medicaid Services Available to EPSDT Beneficiaries

- 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 other medically necessary health care, diagnostic services, treatment, and other measures which are covered by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

Medicaid Services Available to EPSDT Beneficiaries

- 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.
- Medicaid-offered services are more comprehensive than services offered through schools as part of a child's Individualized Educational Plan (IEP). IEPs only cover services that help with a child's *education.* Medicaid, outside of the IEP process, covers services needed to help any other aspect of a child's life, as well.
- Some Medicaid services must be **"prior authorized (PA)"** before the service can be provided.

Medicaid Services Available to EPSDT Beneficiaries

- For a listing of Medicaid services, consult the **Medicaid Services Chart** *(Appendix C)* or go to the website*:* https://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf
- Even if a service is not on the Medicaid services chart, it must still be covered 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.
- The EPSDT-Targeted Support Coordination Training Handbook also provides detailed information about specific services.

EPSDT Support Coordination Services

- Parents of children 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.

EPSDT Support Coordination Services

- 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.**

Applied Behavioral Analysis (ABA)

- ABA based therapies:
  - use behavioral observation and reinforcement to teach skills, increase useful behavior (including communication) and reduce harmful behavior.
  - are based on reliable evidence of their success in alleviating autism and other related disorders and are not experimental.

Applied Behavioral Analysis (ABA)

- For Medicaid to cover ABA services through a licensed provider the person must:
  - Be under the age of 21
  - 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.)
  - Be diagnosed by a qualified health care professional 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 and have a prescription for ABA-based therapy services ordered by a qualified health care professional. (A separate prescription is not needed if the CDE recommends ABA.)

Applied Behavioral Analysis (ABA)

- To find an ABA Provider in your area, call the Managed Care Organization of the beneficiary. Refer to *Medicaid Managed Care Appendix B*.
- 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).
- For more information on ABA contact the beneficiary's MCO *(Medicaid Managed Care Appendix B)* or LDH directly at 1-844-423-4762 and refer to page 11 of the EPSDT SC Handbook.

Transportation Services

- Non-emergency medical transportation (NEMT) is provided for Medicaid beneficiaries to and/or from a provider for a Medicaid covered service.
- All beneficiaries can access this service through their MCO. The transportation phone numbers for each MCO can be found on *Medicaid Managed Care Appendix B*.
- Children under 17 must be accompanied by an attendant.
- Arrangements for non-emergency transportation should be made at least 48 hours in advance.

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 assist the beneficiary in arranging transportation services for the beneficiary.

Gas Reimbursement Transportation Program

- Louisiana Medicaid will allow family members/friends to become Medicaid funded transportation providers for specific family members through the "Gas Reimbursement" transportation program.
- The program pays the beneficiary's friend or family member to take them to medical appointments when certain conditions are met.
- Gas Reimbursement providers may not reside at the same address as beneficiaries that they transport. This includes parents of children in the same household. Beneficiaries cannot be reimbursed for transporting themselves to appointments.
- To assist someone you are serving that may benefit from this arrangement contact the beneficiary's MCO *(Medicaid Managed Care Appendix B)*.

Behavioral Health Services

Coordinated System of Care (CSoC)

- CSoC was developed for Louisiana's children and youth with significant behavioral health challenges or co-occurring 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 children and 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 children 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 child:
  - 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 in an out-of-home placement, or at risk for being placed out of home 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 children 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 Managed Care Organization with the parent/guardian present or on the phone. The Managed Care Organization will ask initial risk questions and 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 brief CANS assessment, a child/youth is eligible for CSoC, Magellan will:
  - refer the child or youth to a **Wraparound Agency** to ensure that a comprehensive assessment is completed, offer the child/youth and the family an opportunity to participate in CSoC and begin forming a child and family team.
- Regardless of CSoC eligibility, their Managed Care Organization will ensure that the child or youth is referred to providers who can meet their needs.

Coordinated System of Care (CSoC)

- Children and youth enrolled in CSoC are assigned a worker called a **Wraparound Facilitator**. The child 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.

Mental Health and Substance Use Disorder Services

The following SPECALIZED BEHAVIORAL HEALTH SERVICES are available to all Medicaid eligible children and youth under the age of 21 who have a medical need:

- Psychiatrist visits
- Psychological and/or behavioral services from a licensed psychologist including:
  - assessments and evaluations, individual therapy, and family therapy.
- Counseling provided by:
  - Doctors, psychologists, medical psychologists, counselors, social workers or advanced practice nurses
- Substance use disorder treatment services including:
  - outpatient and residential substance use disorder services and medication-assisted treatment (MAT)

Behavioral Health Services

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)
- Crisis stabilization (CS)

*Each MCO's Prior Authorization unit must prior authorize CPST and PSR services. CPST and PSR providers arrange the assessments necessary to obtain prior authorization for rehabilitation services.
Note: CSoC enrollees will access these services through Magellan. Services through Magellan do not require PA tracking by SC.

Behavioral Health Services

Licensed Practitioner Outpatient Therapies:

- 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)

More information visit laevidencetopractice.com and refer to Handbook page 16.

Behavioral Health Services

- **Residential and hospital-based behavioral health treatment services:**
  - Therapeutic Group Home care (TGH)
  - Psychiatric Residential Treatment Facility care (PRTF)*
  - Inpatient Hospitalization

*A certificate of need is required prior to admission to a PRTF.

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 Individualized Education Program (IEP).
- 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 Exams and Checkups

- Medicaid beneficiaries under the age of 21 are eligible for well child checkups ("EPSDT Screenings").
- These checkups include: a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; developmental screening; autism screenings; perinatal depression screening; and dental screenings.
- Checkups are available both on a regular basis, and whenever additional health treatment or additional services are needed.
- There are no limits on the number of visits that are **medically necessary** for the beneficiary's condition.

EPSDT Screening Exams and Checkups

- 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 a child's need for health treatment or additional services.

EPSDT Screening Exams and Checkups

- 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.
- PCPs are responsible for making appropriate referrals when needed based on the results of a screening.

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 E* for PCS Rule information and for a comparison of PCS and Home Health Services.
- 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 (Legacy Medicaid) or the MCO (Medicaid Managed Care Program)
- 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.
- 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 doctor stating the number of hours requested and a letter of medical necessity justifying the reason for Extended Skilled Nursing Services.
- Home Health Services for children and 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 a doctor and obtained without prior authorization for beneficiaries aged 0 through 20. These services must still be ordered by a physician 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 Individualized Education Plan (IEP) or Individualized Family Support Plan (IFSP).
- 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 Medicaid.

Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services

- The Support Coordinator is to explain to the beneficiary/family that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP.
- The Support Coordinator is to ask the beneficiary/family if they want to request any medically necessary therapies now or if they want to receive therapies on the IEP 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.

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 R-1* for more information and the prescription request form for disposable incontinence supplies.

Medical Equipment and Supplies

- The Medicaid 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 F* for an expanded list of available services.
- To ask about other available services, contact the Specialty Care Resource Line at 1-877-455-9955 or TTY 1-877-544-9544 or the beneficiary's Managed Care Organization 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 recipient 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 the EPSDT Targeted Population Support Coordination Training Handbook pages 25 and *Appendix G*.

Non-Medicaid Services

- Office of Behavioral Health Services
  - Local Governing Entities – Community Behavioral Health Services
  - CART (child/adolescent response teams)
  - Refer to the EPSDT Targeted Population Support Coordination Training Handbook page 28 and *Appendix I*.
- 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 the EPSDT Targeted Population Support Coordination Training Handbook pages 28-30.
- 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

- New Opportunities Waiver (NOW) – which provides comprehensive home and community based services for individuals three years of age or older.
- See Appendix D-1.
- Children's Choice Waiver – which provides a limited package of services to children under the age of 21.
- See Appendix D-2.

Home and Community Based Waivers for People with Developmental Disabilities

- Supports Waiver – which provides specific, activity focused services for those age 18 years and older.
- See Appendix D-3.
- Residential Options Waiver (ROW) – which offers expanded home and community based services for individuals of all ages.
- See Appendix D-4.

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, have the highest level of need and the earliest registry date as slots become available.
- Services are capped at $20,200 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?

- The beneficiary becomes ineligible for some services at age 21, including support coordination, EPSDT Personal Care Services, Extended Home Health Services, incontinence supplies, and other items or services that are not part of Medicaid services for adults. Inform the beneficiary of the change in Medicaid services and encourage them to obtain exams, dental care, glasses, DME, etc. prior to aging out.
- The support coordinator 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.
- The support coordinator should begin making arrangements for transition at least 6 months prior to the beneficiary's 21st birthday.
- Provider agencies may need to be changed if the current provider only services children.

What Happens at Age 21?

Available services may include:

- OCDD services, including (in addition to those listed previously) extended family living, supported independent living, and vocational and rehabilitative services. Refer to *Appendix G*.
- 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.

Intake, Assessment and CPOC

How to Access EPSDT Support Coordination

- EPSDT Support Coordination is available to all Medicaid beneficiaries under the age of 21 who are on the Developmental Disabilities Request for Services Registry (DD RFSR) or for whom the service is determined medically necessary, with documentation from Medicaid to substantiate that the EPSDT beneficiary meets the definition of special needs *(Appendix P).*
- 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 *(Appendix G).*
- 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 *(Appendix P).*

Intake

- Contact the beneficiary and/or legal guardian within 3 business days of the referral to the Support Coordination Agency (linkage).
- 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 (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 N* for a sample copy of the consent form.

Medicaid Eligibility Verification

- The support coordinator shall use MEVS/REVS or e-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 EPSDT Targeted Population Support Coordination Training Handbook page 113.

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.
- 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 Support Coordinator must explain and review the following with the individual:
  - Medicaid Services Chart *(Appendix C)*
  - Services Available to Medicaid Eligible Children Under Age 21 *(Appendix F)*
  - Support Coordination Responsibilities and Participant Rights and Responsibilities *(Appendix K)*
  - Appeal Process *(Appendix L)*
  - Complaint Process for filing a report against support coordinators and/or Legacy Medicaid Providers *(Appendix M)*
  - Discuss with Chisholm Class Members their 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 *(MMC Appendix I)*
  - 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.**

Assessment

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

Comprehensive Plan of Care (CPOC)

- The Comprehensive Plan of Care (CPOC) is the Support Coordinator's blueprint for assisting the individual.
- The CPOC is developed through a person-centered planning process and is based on the comprehensive information gathered during the assessment process which identifies the individual's preferences, needs, goals, abilities, health status and available supports.

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 Authorized Representative form *(Appendix U)*.
- 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 U)* or a supported decision-making (SDM) agreement.

Refer to pages 33-34 of the Handbook 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 the Medicaid Services Chart *(Appendix C)* 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, inform the individual and document their response.**
- 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)

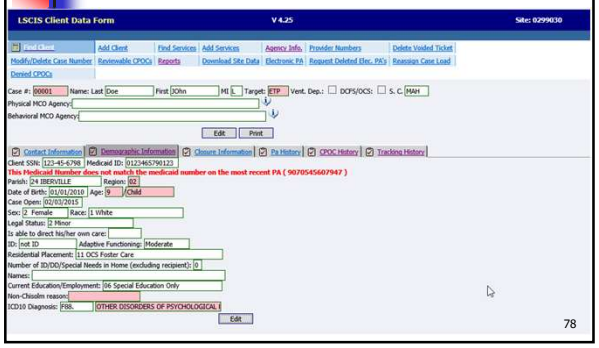
The CPOC is comprised of the following six sections:

- 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

- Provide information about the past and current situations in the beneficiary's life and about their family.
- Interview those who know the beneficiary best.
- Natural supports should be explored to determine who is involved in the beneficiary's social support network.
- Information included on this section 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.**

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.
  - 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 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.
  - 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 diagnosis or has even been labeled, even informally, as having Autism, 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.
  - 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.

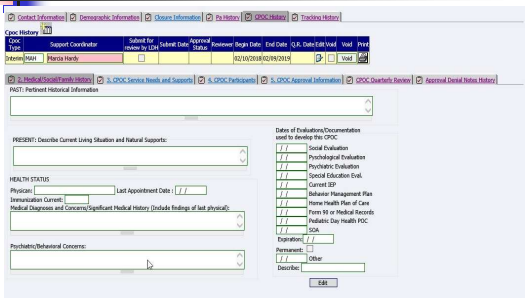
CPOC Section 2 – Medical / Social / Family History

- **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, <u>or</u> 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 <u>or</u> 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 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 attain 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.
- 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

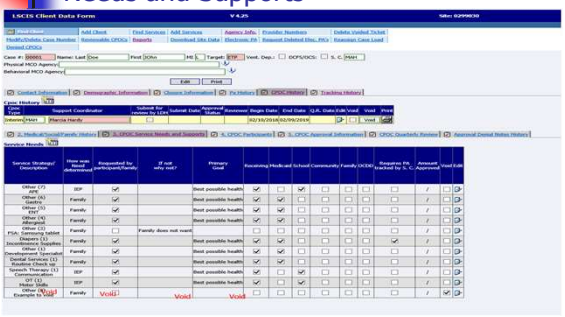
- Select the primary goal from the picklist.
- Use the checkbox to indicate if the service is currently received.
- Check the appropriate box of who will be providing/funding the service need – Medicaid, School, Community, Family (private insurance or out of pocket), or OCDD.
- **"Requires PA tracked by SC" must be checked for all requested Medicaid services that require a PA, unless both a valid reason 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:
  - If the PA is issued monthly.
  - If the EHH nurse is the person ordering and tracking medical supplies.
  - If the beneficiary is on a waitlist for the service - SC must offer alternative providers for whom there may not be a waitlist and document response, confirm waitlist placement with the provider, notify the LDH PAL (Legacy Medicaid service) or the MMCCM (MMC service), and follow up with the provider at least quarterly to ensure they move up the waitlist.
  - For community OT, PT, ST: Before completing a 35/60 day PAL referral if you can confirm with the family and the provider that the service is being delivered a PAL referral and continued PA tracking would not be needed. When the SC receives a PA it is to be entered on a tracking log and PA tracking will restart. *(Refer to Appendix R-4).*
  - If the MCO does not require a PA for the service.
  - If the beneficiary's behavioral health services are being prior authorized by Magellan while the child is enrolled in CSoC, PA tracking is not required.

Refer to page 60-63 of the Handbook 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, confirm that you offered alternative providers that may not have a waitlist and response received, identify that the waitlist placement was confirmed with the provider and the SC notified LDH PAL (Legacy Medicaid services) or the MMCCM (MMC Services). Also explain how you will ensure they move up the waitlist (must follow up with provider at least quarterly).
  - 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 *(Appendix B)* and Medicaid EPSDT Services (Services Available to Medicaid Eligible Children Under 21 - *Appendix F)*
  - 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.)

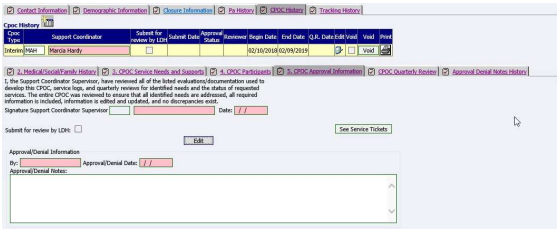
CPOC Section 5 – CPOC Approval Information

- For initial CPOCs, *Appendix X-1* and the required documents must be sent to BHSF/SRI including the evaluations and supporting documentation from the LGE and must be received prior to CPOC approval.
- A beneficiary may be identified as "Special Needs" by BHSF/SRI if the beneficiary received a Statement of Denial from OCDD. Special Needs beneficiaries must have *Appendix X-1* submitted to BHSF/SRI with all annual CPOCs and must include current formal information documents to document that they continue to qualify for EPSDT Support Coordination.
- If the CPOC is randomly selected for monitoring when it is submitted to BHSF/SRI for approval, *Appendix X-2* and the required documents must be submitted to BHSF/SRI.
- 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. This 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.

Coordination of Services

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 make referrals to the appropriate providers. **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.

4.3.23 EPSDT Support Coordination Training 112

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. Medicaid Services Chart *(Appendix C).*
- 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, if you are properly identified in the request. The beneficiary then has the right to appeal the denial.

4.3.23 EPSDT Support Coordination Training 113

Coordination of Services

- For beneficiaries in Legacy Medicaid for their physical health services, 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 beneficiaries in Managed Care Organizations (MCO) for their physical health services and/or behavioral health services, prior authorization is handled by the individual MCO.
- The beneficiary's Managed Care Organization must prior authorize some Specialized behavioral health services including CPST, PSR, ACT (ages 18-20), FFT/CWFFT, Homebuilders, and MST unless they are enrolled in the Coordinated System of Care (CSoC). For children and youth enrolled in CSoC their behavioral health services are authorized by Magellan, except PRTF and substance use residential services.

4.3.23 EPSDT Support Coordination Training 114

Important Information About Medicaid Services

- Legacy Medicaid
  - Traditional Medicaid for people who are not enrolled in a Managed Care Organization for most of their health services.
- Medicaid Managed Care Program
  - Managed care system for physical health, specialized basic behavioral health and non-emergency medical transportation services.
  - Covers 1.6 Million Louisianans
  - Five managed care organizations (MCOs) working statewide:
    - Aetna Better Health
    - AmeriHealth Caritas
    - Healthy Blue
    - Humana Healthy Horizons
    - Louisiana Healthcare Connections
    - UnitedHealthcare Community

Important Information About Medicaid Services

- Chisholm Class Members are part of the Voluntary Opt-In Population for **Physical Health Services.**
  - May enroll in a MCO for their physical health services at any time.
  - May disenroll from a MCO for their physical health at anytime effective the earliest possible month that the action can be administratively taken.
  - For more information on opting in and disenrolling from the Medicaid Managed Care Program for physical health services refer to *MMC Appendix H* or contact the Medicaid Managed Care Program hotline toll free at 1-855-229-6848.

Important Information About Medicaid Services

- All Medicaid beneficiaries will have a Managed Care Organization (MCO) for their **specialized behavioral health services** unless they are enrolled in the Coordinated System of Care Waiver (CSoC) in which case most of their specialized behavioral health services will be accessed through Magellan.
- All Medicaid beneficiaries will have a Managed Care Organization (MCO) for their **transportation services**.

Medicaid Eligibility Verification

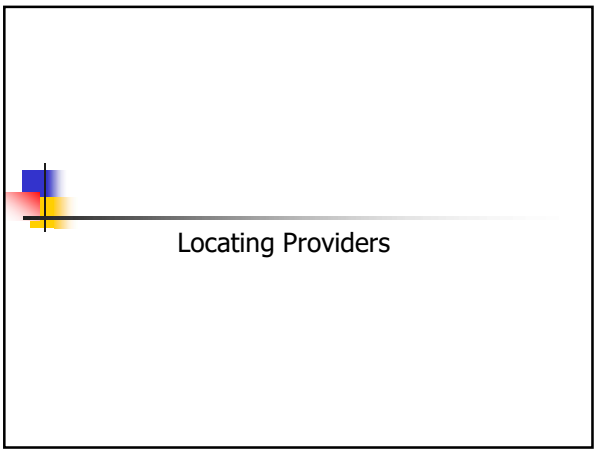
- Support coordinators are required to validate EPSDT beneficiaries Medicaid eligibility through MEVS/REVS or e-MEVS **at the beginning of every month**.
- The Medicaid Eligibility Verification will provide the SC with current information on the beneficiary's Medicaid coverage including their Managed Care Organization's information.
- Statistical Resources, Inc. (SRI) will seed the Physical MCO Agency and the Behavioral MCO Agency fields in LSCIS based on the data file SRI receives from Gainwell Technologies.
  - If the Physical MCO Agency field is blank, the beneficiary has Legacy Medicaid for their physical health services.
  - If the Behavioral MCO Agency field is blank, the beneficiary is enrolled in the Coordinated System of Care (CSoC) and is receiving their specialized behavioral health and CSoC services from the CSoC Contractor, Magellan Health Services of Louisiana.

Coordination of Services

- The Support Coordinator plays a role in the prior authorization process by:
  - assisting beneficiaries in identifying services they will request (discussed previously);
  - providing the specific medical information forms, that the physician must complete, for the requested services (Refer to *Appendix R-1*, LaMedicaid.com or the LDH website);
  - 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;

Coordination of Services

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



Physical Health Services

- Physical Health Services will either be accessed:
  - through Legacy Medicaid if the beneficiary has Legacy Medicaid for physical health services,
  - or through the beneficiary's Managed Care Organization if they chose to "opt in" to the Medicaid Managed Care Program for their physical health services.

Locating Legacy Medicaid 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 Legacy Medicaid Providers for Physical Health Services

- A list of available providers is available through the Medicaid website at www.medicaid.la.gov.
- 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.
- The direct website address to find a provider is: https://www.lamedicaid.com/apps/provider_demographics/provider_map.aspx

Locating Medicaid Managed Care Providers for Physical Health Services

- Support Coordinators should assist with locating a provider contracted with their MCO.
- Resources for locating providers include:
  - Online Provider Directory at www.myplan.healthy.la.gov.
    - Select Choose > Find a Provider.
    - Choose Medical Health Providers.
    - Indicate if you know the provider's name or phone number.
      - You can look up a specific provider to see what Health Plans they are affiliated with by selecting "Yes" and then entering the Doctor/Provider's name.
      - If you select "No" you can search by Provider Location and then select the Provider Specialty and narrow the results down further by provider gender (for doctors), provider language or Healthy Plan.
      - Note: You can search for PCS by selecting Personal Care Attendant and looking for "PCS-EPSDT" listed under PCP/Specialties on the list of providers.
  - Call the Member Services Line at each MCO to locate a provider in their network *(Medicaid Managed Care Appendix B)*
  - Access MCO websites to identify contracted providers.

Behavioral Health Services

- Behavioral Health Services will either be accessed:
  - through the beneficiary's Managed Care Organization for specialized behavioral health services,
  - or through Magellan if the beneficiary is enrolled in the Coordinated System of Care (CSoC) waiver.

Locating Behavioral Health Providers - Medicaid Managed Care

- Support Coordinators should assist with locating a provider contracted with their MCO.
- Resources for locating providers include:
  - Online Provider Directory at www.myplan.healthy.la.gov.
    - Select Choose > Find a Provider.
    - Choose Behavioral Health Providers.
    - Indicate if you know the provider's name or phone number.
      - You can look up a specific provider to see what Health Plans they are affiliated with by selecting "Yes" and then entering the Doctor/Provider's name.
      - If you select "No" you can search by Provider Location and then select the Provider Specialty and narrow the results down further by provider gender (for doctors), provider language or Healthy Plan.
  - Call the Member Services Line at each MCO to locate a provider in their network *(Medicaid Managed Care Appendix B)*
  - Access MCO websites to identify contracted providers.

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 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 beneficiary's wraparound facilitator can also assist with accessing specialized behavioral health services.

Note: PRTF and substance use residential services will be prior authorized by their Managed Care Organization.

Transportation Services

- The transportation phone numbers for each MCO can be found on *Medicaid Managed Care Appendix B*.

Dental Services

- Contact the beneficiaries 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.

Waitlist Placement

- 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 might not be a waiting list and the response received.
- For Legacy Medicaid services, the SC must notify the LDH PAL of waitlist placement *(Appendix S).*
- For Medicaid Managed Care services, the SC must notify the MMCCM *(MMC Appendix Q).*
- The SC must follow up on waitlist placement with the provider at least quarterly to ensure they move up the waitlist.

What if you are unable to locate a Legacy Medicaid provider?

- If you are unable to locate a Legacy Medicaid provider for a Chisholm class member, call the contact person listed on the Medicaid Services Chart *(Appendix C)* 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 fax the Referral to LDH PAL form *(Appendix Q).* 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 Medicaid Managed Care Program 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 must fax the Referral to Medicaid Managed Care Case Management (MMCCM) form *(Medicaid Managed Care Appendix Q)* within 3 days of the date of service request to get assistance from the MCO with locating a provider.
- If the MCO is unable to locate a willing provider within 10 days of the Referral to MMCCM, the SC should submit a referral to the LDH PAL using *Medicaid Managed Care Appendix S.* LDH will forward the referral to the MCO requesting notification upon resolution.

What if a Legacy Medicaid provider is unable to find staff?

- If the provider is unable to find staff after the service has been approved, the support coordinator must notify the LDH Prior Authorization Liaison (PAL) using the Referral to LDH PAL form *(Appendix S).*
- 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 Medicaid Managed Care 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 should fax the Referral to Medicaid Managed Care Case Management form *(Medicaid Managed Care Appendix Q)* to the MCO to request assistance.
- If the MCO is unable to resolve the issue within 10 days of the Referral to MMCCM, the SC should submit a referral to the LDH PAL – Medicaid Managed Care Member using *Medicaid Managed Care Appendix S.* LDH will forward the referral to the MCO requesting notification upon resolution.

Coordination of Services

- 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.
- To begin PA tracking, add the service as a Service Need on the CPOC Service Needs and Supports in LSCIS and check the "Medicaid" and "Requires PA tracked by SC" boxes for that Service Strategy.
- Then follow the prompts on the Tracking Required Action Report beginning with opening an EPSDT Prior Authorization Tracking Log.

Coordination of Services – EPSDT 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.
- A new **Renewal** tracking log is used for each PA cycle after the reminder notice for renewals is sent to the provider/MMCCM. 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.
- 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.

Coordination of Services – EPSDT 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.

Coordination of Services – EPSDT Prior Authorization Tracking Log

The electronic EPSDT Prior Authorization Tracking Log provides space for ongoing tracking information relating to the status of the prior authorization/service including:

- Type of Service Requested
- Type of Request and Amount
- Date of Service Request
- Date of COP (Choice of Provider)
- Provider
- Date of Referral to Provider/MMCCM
- Required Provider/MMCCM Contacts
- Date Packet Submitted to FI (Fiscal Intermediary i.e. Gainwell or MCO)
- Date Provider PA Request Packet Received
- Date of Decision
- Date PA Notice Received
- Date of Referral to LDH PAL (if required)
- Amount approved
- PA Approval and Dates
- Appeal Information

Coordination of Services

- Support Coordinators should:
  - Give the individual a Choice of Providers (unless they are already satisfied with a provider).
  - Assist the individual in contacting prospective providers and finding out if they are willing to submit prior authorization requests.
  - Have the individual list the provider they choose and sign the Choice of Provider Form for EPSDT Medicaid Providers *(Appendix Z).*
  - Give the individual the medical information forms that are required for the specific service. Many forms can be found in *Appendix R-1*.
  - Assist with scheduling the doctor appointment, transportation, etc., as needed.
  - Assist the individual/provider in gathering the appropriate documentation needed to support the request.

Tracking Required Actions for Legacy Medicaid

- Once the beneficiary has chosen a provider, the Support Coordinator must complete the **Referral to Provider *(Appendix Q)*** form and submit it to the provider within 3 calendar days of the date of choice of provider. (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.)

Tracking Required Actions for Legacy Medicaid

Provider Contacts

- **Within 15 calendar days of the referral**, 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**, contact the provider and ask if the request has been submitted to Medicaid or if there were problems that you could assist with.
- If a notice of decision has not been received 10 calendar days after the date the provider said they submitted the request.
- If a call from the PAL has been received.
- 45 – 60 calendar days prior to the date the services are scheduled to expire, you should remind the provider to renew the prior authorization request. The provider must submit the renewal request at least 25 calendar days prior to expiration to assure uninterrupted services. (Refer to *Appendix T-2* for the contact flow sheet.)

Tracking Required Actions for Legacy Medicaid

Prior Authorization Liaison (PAL) Referrals

- If a Prior Authorization packet has not been submitted within **35 calendar days**, complete the Referral to LDH PAL form *(Appendix S)* and submit it to the LDH PAL. Also inform the beneficiary about their right to change providers.
- If a Prior Authorization decision has not been received within **60 calendar days**, complete the Referral to LDH PAL form *(Appendix S)* and submit it to the LDH PAL. Also inform the beneficiary about their right to change providers.

Tracking Required Actions for Legacy Medicaid

Other reasons to submit a Referral to the LDH PAL are:

- To alert the PAL that a renewal approval has not been received and the previous PA has expired;
- To alert the PAL that a provider cannot be located to submit a request for prior authorization;
- To alert the PAL that the provider has placed the beneficiary on a waitlist for the requested prior authorized service;
- To alert the PAL that a provider is not providing services at the times the beneficiary requested and/or the amount of services prior authorized and the problem cannot be resolved.

LSCIS Prior Authorization Tracking Log for Legacy Medicaid

Tracking Required Actions for Medicaid Managed Care

- Once the beneficiary has requested a service, the Support Coordinator must complete the **Referral to Medicaid Managed Care Case Management** *(Medicaid Managed Care Appendix Q)* form and submit it to the Medicaid Managed Care Case Manager (MMCCM). Fax numbers for the MMCCMs can be found on *Medicaid Managed Care Appendix A*. (Referral to Medicaid Managed Care Case Management should be made within 3 calendar days of CPOC completion, or within 3 calendar days of the date of service request if the date of service request is later than the CPOC meeting.)
- A second Referral to Medicaid Managed Care Case Management should be made within 3 calendar days of the date of choice or provider (if the provider was not known upon the request for service).

Tracking Required Actions for Medicaid Managed Care

- 1st Referral to Medicaid Managed Care Case Management = let MCO know the service is requested.
- 2nd Referral to Medicaid Managed Care Case Management = let MCO know the choice of provider.
- Referral to Medicaid Managed Care Case Management = for Renewals or if the date of service request and the choice of provider date are the same, only one Referral is needed. You will not see the 2nd Referral teal boxes on your tracking log.

4.3.23 EPSDT Support Coordination Training 148

Tracking Required Actions for Medicaid Managed Care

Provider/Medicaid Managed Care Case Management (MMCCM) Contacts

For Initial PA requests if COP is not known:

Send **1st** Referral to MMCCM and complete these contacts:

- **Within 15 calendar days from 1st referral**, contact MMCCM to check on status of referral and seek assistance with choice of provider.
- **Within 35 calendar days of 1st referral,** contact MMCCM to check on status of referral and seek assistance with choice of provider.

Once a choice of provider is made, send **2nd** Referral to MMCCM and move to these contacts:

- **Within 15 calendar days from 2nd referral**, contact provider or MMCCM to check on status of referral and offer assistance if needed.
- **Within 35 calendar days of 2nd referral,** contact provider or MMCCM to check on status of referral and offer assistance if needed.
- If PA packet has not been submitted to MCO, seek assistance from MCO and continue to follow up with provider and MMCCM until packet is submitted.

4.3.23 EPSDT Support Coordination Training 149

Tracking Required Actions for Medicaid Managed Care

Provider/MMCCM Contacts

For Renewals or if date of service request is the same as date of choice of provider.

- **Within 15 calendar days from referral**, contact provider or MMCCM to check on status of referral and offer assistance if needed.
- **Within 35 calendar days of referral,** contact provider or MMCCM to check on status of referral and offer assistance if needed.
- If PA packet has not been submitted to MCO, seek assistance from MCO and continue to follow up with provider and MMCCM until packet is submitted.

4.3.23 EPSDT Support Coordination Training 150

Tracking Required Actions for Medicaid Managed Care

Provider/MMCCM Contacts

- Contact should be made if a notice of decision has not been received **10 calendar days after the date the provider submitted the request** or a call from the PAL has been received;
- **20 – 60** calendar **days prior to the date the services are scheduled to expire**, you should remind the MMCCM to renew the prior authorization request.

Tracking Required Actions for Medicaid Managed Care

LDH PAL Referrals

- If after 60 calendar days from the Choice of Provider date the Support Coordinator has not received a decision and the MCO has been unable to resolve the issue, the Support Coordinator must complete the Referral to LDH PAL – Medicaid Managed Care Member*(Medicaid Managed Care Appendix S).*

Tracking Required Actions for Medicaid Managed Care

MMCCM Referrals

- The Support Coordinator must submit a Referral to Medicaid Managed Care Case Manager (*Medicaid Managed Care Appendix Q) :*
  - To alert the MCO that you have been unable to locate a willing provider;
  - To alert the MCO that a renewal approval has not been received and the previous PA has expired; or
  - To alert the MCO that a provider is not providing services at the time the beneficiary requested and/or the amount of services prior authorized and the problem cannot be resolved.
  - To alert the MCO that the member was placed on a waitlist.

Tracking Required Actions for Medicaid Managed Care

LDH PAL Referrals

- If the MCO has been unable to resolve the issue within 10 days of the Referral to MMCCM, the Support Coordinator should complete the **Referral to LDH PAL - Medicaid Managed Care Member** *(Medicaid Managed Care Appendix S)* for the following reasons:
  - To alert the LDH PAL that you have been unable to locate a willing provider;
  - To alert the LDH PAL that a renewal approval has not been received and the previous PA has expired; or
  - To alert the LDH PAL that a provider is not providing services at the time the beneficiary requested and/or the amount of services prior authorized and the problem cannot be resolved.

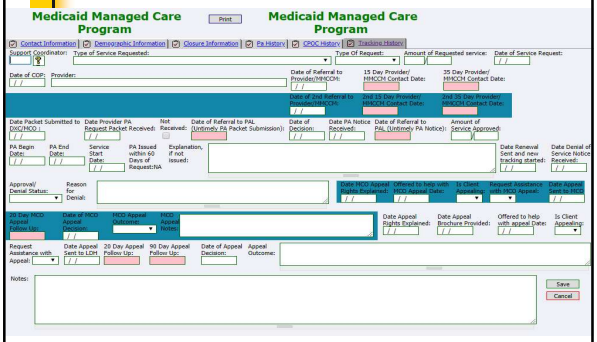
Tracking Required Actions for Medicaid Managed Care

LDH PAL Referrals

- Prior to sending the **Referral to LDH PAL - Medicaid Managed Care Member** *(Medicaid Managed Care Appendix S),* the Support Coordinator should document all contacts and all attempts to contact the MCO PAL and Medicaid Managed Care Case Manager.
- The Support Coordinator must attach the completed **Referrals to Medicaid Managed Care Case Management** *(Medicaid Managed Care Appendix Q)* along with all logs and e-mails related to resolving the issue with the MCO PAL.

Note: If the PA notice is not received from the provider, the MCO can give you the PA information over the phone. Do NOT take verbal PA information from providers.

LSCIS Prior Authorization Tracking Log for Medicaid Managed Care Program Services



Coordination of Services – Renewals of Prior Authorization for Legacy Medicaid Services

- 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 Legacy Medicaid services, the Support Coordinator must send a reminder letter (Referral to Provider - *Appendix Q)* to the provider **no less than 45 or more than 60 calendar days** prior to the expiration of the prior authorization.

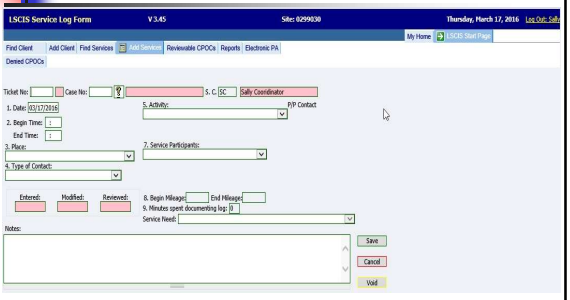
Coordination of Services – Renewals of Prior Authorization for Medicaid Managed Care Services

- 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.
  - For Medicaid Managed Care services, the SC must send a reminder letter (Referral to Medicaid Managed Care Case Management - *Medicaid Managed Care Appendix Q)* to the Medicaid Managed Care Case Manager **no less than 20 days or more than 60 calendar days** prior to the expiration of the prior authorization.

Coordination of Services – 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



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.

Prior Authorization Liaison

- 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

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 to 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.

Prior Authorization Liaison

- Contacts
  - **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
  - **LDH PAL**
    Nancy Spillman
    nancy.spillman@la.gov
    (225) 342-7873
    Fax: (225) 389-2749 or
    1-877-747-0997

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

Prior **A**uthorization **L**iaison MCOs

Refer to *Medicaid Managed Care Appendix A*
for a list of MCO Prior Authorization Liaison contacts at each MCO.

Prior **A**uthorization **L**iaison

Refer to *Appendix R* –
Medicaid Prior Authorization Packet.

Refer to *Appendix R-3* for
a sample of the PAL notices.

Prior **A**uthorization **L**iaison

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.

Appeals / Reduction in Service

- If a beneficiary's service is denied or partially denied, the EPSDT Prior Authorization Tracking Log and EPSDT LSCIS Service Log should document:
  - 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.

Medicaid Managed Care - Appeals / Reduction in Service

- For services authorized by the Medicaid Managed Care Program that are denied or partially denied, the beneficiary, provider, and the Support Coordinator will receive notice of denial.
- If services are denied or partially denied, the beneficiary may appeal the decision by following the appeals procedures sent to them, the provider, and the Support Coordinator by the Managed Care Organization following the denial or partial 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. Refer to *Medicaid Managed Care Appendix F and T-1.*

Appeals / Reduction in Service

- For beneficiaries with Legacy Medicaid or for those with the Medicaid Managed Care Program 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

Appeals / Reduction in Service

- 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 can be continued pending appeal if the appeal is filed within 10 days of the notice of denial.
- 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.

Appeals / Reduction in Service

- Regardless of whether or not the support coordinator is assisting with the appeal, they must follow-up with the beneficiary within **20 calendar days** of the appeal request to see if they have received a response, and/or need additional assistance.
- The support coordinator should follow-up again with the beneficiary at least **90 calendar days** after the appeal was sent to check on the final decision regarding the appeal.
- Review the Appeals section of the EPSDT SC Training Handbook (pages 97-102).

Other Requirements

Follow-up Requirements

- 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.
- The support coordination must make contact with the beneficiary **at least monthly** to assure implementation of the services requested on the CPOC.

Follow-up Requirements

- If the beneficiary is not satisfied with their provider, the support coordinator shall follow-up with the provider.
- If the issue cannot be resolved, the support coordinator will:
  - alert the LDH PAL using Referral to PAL – *Appendix S* for Legacy Medicaid services.
  - alert the MCO using the Referral to MMCCM Form – *Appendix Q* for Medicaid Managed Care services. If the MCO cannot resolve the issue within 10 days of the Referral, alert the LDH PAL using Referral to LDH PAL – Medicaid Managed Care Member - *MMC Appendix S.*

Follow-up Requirements

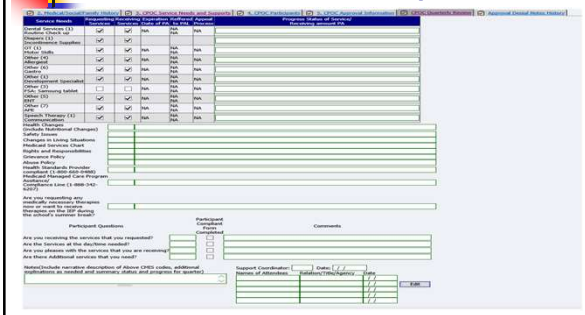
- The support coordinator must complete a face-to-face visit with the beneficiary and parent/legal guardian each quarter in order to identify:
  - Service needs and status through review of the CPOC. The service needs section of the Quarterly Review should document if services are received and if the 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.

Note: The face-to-face quarterly visit does not have to be completed in the beneficiary's home however the CPOC meeting (Initial and Annual) must be held at the beneficiary's home. The original signature page must be kept in the case record. Refer to pages 94-95 for instructions on completing the Quarterly Review.

Follow-up Requirements

- If any complaints against support coordinators or Legacy Medicaid providers are detected as a result of the Quarterly Review, the beneficiary should be given the Participant Complaint form *(Appendix M)* to complete and return to Health Standards.
- 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 let the beneficiary know of his/her right to change providers.
- If the beneficiary has a complaint against their Managed Care Organization they should be given Medicaid Managed Care Complaints form *(MMC Appendix I)* 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 MMC provider or a MCO.

LSCIS CPOC Quarterly Review



Follow-up Requirements

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

Follow-up Requirements

- 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. 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.

Follow-up Requirements

- 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 the Quarterly Report Checklist (*Appendix W-1)* and the report must include:
  - A print out of the Quarterly Report From LSCIS (reviewed and signed)
  - Quarterly Report of CPOC Revisions *(Appendix W-2)* with a print out of the Service Needs Changes Report attached
  - Record Reviews *(Appendix W-3)* for PAs not issued within 60 days and Gaps in Prior Authorization Periods
  - Explanation of beneficiaries without a Choice of Provider
  - Documentation of EPSDT Training for any new hires

Follow-up Requirements

- The report will include the names of the beneficiaries and the services for the following:
  - Beneficiaries with PAs not issued within 60 calendar days
  - Beneficiaries with service gaps in the authorization period
  - Beneficiaries who submitted requests for appeals within the quarter
- The **Record Review for the Quarterly Report** is to be completed for each beneficiary and each service listed on the LSCIS Quarterly Report as not having a PA issued within 60 calendar days or a Gap in Authorization Period. 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.

Follow-up Requirements

- 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, the onsite manager and supervisor are to complete the record review.
- Either the number of trackings without a choice of provider must be zero or documentation and explanation must be attached for each beneficiary and service 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.

Requirements for Support Coordination Agencies

- All **Support Coordinators** must receive EPSDT training.
  - New support coordinators and trainees must receive EPSDT training:
    - during orientation, and
    - prior to being assigned an EPSDT caseload.
  - All support coordinators and trainees 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.

Requirements for Support Coordination Agencies

- All **Trainers and Supervisors** must receive EPSDT training.
  - Newly designated EPSDT Trainers and Supervisors must receive EPSDT training:
    - during orientation, and
    - prior to beginning supervision of EPSDT support coordinators.
  - All designated Trainers and Supervisors must complete EPSDT training each year as part of their 20 hours of annual training. The training may be provided by BHSF/SRI or by a trained supervisor or designated trainer within the agency.

Requirements for Support Coordination Agencies

- 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.

Requirements for Support Coordination Agencies

LSCIS Reports

- 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. **They both shall check the LSCIS reports at least semiweekly. All deficiencies are to be addressed and resolved.**
- Refer to Handbook page 121-125.

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 BHSF/SRI if you have questions or your BHSF State Office regarding policy.

Part 2

Medicaid Managed Care Program

Purpose of the Training

To provide an overview of the Medicaid Managed Care Program for the Support Coordination Agency's Designated Trainers and Supervisors to use in conjunction with the Support Coordination Training Handbook and the Medicaid Managed Care Appendices.

What is the Medicaid Managed Care Program?

- Managed care system for physical health and specialized behavioral health services.
- Covers 1.6 Million Louisianans
- Five managed care organizations (MCO) working statewide:
  - Aetna Better Health
  - AmeriHealth Caritas
  - Healthy Blue
  - Humana Healthy Horizons
  - Louisiana Healthcare Connections
  - UnitedHealthcare Community

Chisholm Class Members in the Medicaid Managed Care Program

- Most Healthy Louisiana Members will receive all their Medicaid covered services through their Health Plan.
- Chisholm Class Members (CCM) may choose to have all of their health care through the Health Plan or only their specialized behavioral health services. This is called "opt-in."
  - May enroll in a MCO for their physical health services at any time.
  - May disenroll from a MCO for their physical health services and go back to regular Medicaid at anytime effective the earliest possible month that the action can be administratively taken.

Chisholm Class Members in the Medicaid Managed Care Program

- Some Medicaid beneficiaries only receive specialized behavioral health and transportation services through their Health Plan.
- Coordinated System of Care (CSoC) beneficiaries will receive coverage for all covered services except their specialized behavioral health and Coordinated System of Care (CSoC) services which will be received from the CSoC Contractor, Magellan Health Services of Louisiana.

Enrollment / Disenrollment

- Plan change effective dates are always on the 1st day of the month.
- Any transfer request processed on or before the 2nd to last business day of the month will be effective the following month.
- 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.
- CCMs 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 November 8, 2022 and 6 p.m. on March 31, 2023.

Disenrollment Periods

- 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 the Medicaid Managed Care Program or show cause for disenrollment from the MCO.

Enrollment / Disenrollment Examples

Enrollment:

- CCM calls the Healthy Louisiana Line to enroll on April 8th, the effective date of enrollment for the MCO of choice will be May 1st.
- CCM calls the Healthy Louisiana Line to disenroll on April 8th, the effective date of enrollment back into Legacy Medicaid will be May 1st.

Cut Off:

- CCM calls the Healthy Louisiana Line on April 30th to enroll in the MCO, the effective date of enrollment will be June 1st.
- CCM calls the Healthy Louisiana Line on April 29th to enroll, their effective date will be May 1st.

Request and Process Date	Effective Date
4/8/22	5/1/23
4/30/22	6/1/23

Enrollment / Disenrollment

- For more information on opting-in and disenrolling from the Medicaid Managed Care Program for physical health services:
  - refer to *MMC Appendix H*
  - contact the Healthy Louisiana Line toll-free at 1-855-229-6848.

5 Ways Chisholm Class Members can Change Their Health Plan

CCMs 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 PO Box 1097, Atlanta, GA 30301-9913

Services Excluded from the Medicaid Managed Care Program

- Dental services with the exception of varnish provided in a primary care setting, surgical dental services, and emergency dental services
- ICF/DD Services
- Nursing Facility Services
- Individualized Education Plan (IEP) Services
- All Home and Community-Based Waiver Services
- Targeted Case Management Services
- Services provided through LDH's EarlySteps Program
- Personal Care Services for those ages 21 and over

Services Excluded from the Medicaid Managed Care Program

- MCO members may obtain excluded services under the Louisiana State Plan; however, Gainwell will pay for these services, not the MCO. The MCOs are responsible for informing members how to access excluded services and assisting in the coordination of these services.
- The Support Coordinator should reach out to Medicaid Managed Care Case Management for assistance with obtaining excluded services.

Value Added Benefits

- 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 *(Medicaid Managed Care Appendix G)*.

Value Added Benefits

- Examples of Value Added Benefits include:
  - $10 reward for completing health needs assessment, flu shot, etc.
  - GED test preparation
  - Life skill and workforce training
  - Cell phone and service
  - Gym memberships and weight management programs

Medicaid Managed Care Program - Support Coordination Role

Support Coordination Role - Selecting a Health Plan

- Support Coordinators should assist CCMs with selecting a MCO by providing information on all 5 plans using the MCO Comparison Chart *(Medicaid Managed Care Appendix G).*
- Support Coordinators should ensure that the CCMs providers are in-network. Each plan has PCPs and specialists in their provider network. You can search for providers by plan at: MyPlan.healthy.la.gov.

Support Coordination Role - Selecting a Health 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 page 8 for links to each MCOs pharmacy benefits page.

Support Coordination Role - Selecting a Health Plan

- Questions for CCMs to answer:
  - Is your PCP in the health plan's provider network?
  - Are specialists you see in the health plan's network?
  - Are specialists and behavioral health providers you see in the health plan's network?
  - What special services does the health plan offer?
  - » Use the health plan comparison chart *(MMC Appendix G)*
- CCMs can call the Healthy Louisiana Line at 1-855-229-6848 (TTY: 1-855-526-3346) to enroll or go online at MyPlan.healthy.la.gov.

Support Coordination Role - Continuation of Services

- 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.

What should a CCM expect after enrolling in the Medicaid Managed Care Program?

- Within 10 days of a member enrolling in the Medicaid Managed Care Program, 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.

Member Handbooks

- Support Coordinators should familiarize themselves with the Member Handbooks for each MCO:
  - Aetna Better Health: http://www.aetnabetterhealth.com/louisiana/assets/pdf/members/MemberHandbook-Eng-LA.pdf
  - AmeriHealth Caritas: http://www.amerihealthcaritasla.com/pdf/member/handbook/english.pdf
  - Healthy Blue: https://www.myhealthybluela.com/la/benefits/member-resources.html
  - Humana Healthy Horizons: https://apps.humana.com/marketing/documents.asp?file=4960826
  - Louisiana Healthcare Connections: https://www.louisianahealthconnect.com/content/dam/centene/louisiana-health-connect/pdfs/medicaid-member/Member-Handbook-Integrated.pdf
  - UnitedHealthcare Community: https://www.uhccommunityplan.com/assets/plandocuments/handbook/en/LA-Integrated-Health-Services-Handbook-EN.pdf

Member Services Numbers

- Aetna Better Health
  - 1-855-242-0802
- AmeriHealth Caritas
  - 1-888-756-0004
- Healthy Blue
  - 1-844-521-6941
- Humana Healthy Horizons
  - 1-800-448-3810
- Louisiana Healthcare Connections
  - 1-866-595-8133
- UnitedHealthcare Community
  - 1-866-675-1607

Support Coordination Role - Accessing Services

- Support Coordinators should utilize the *Medicaid Managed Care Appendix A and B* to contact the MCO to determine how the CCM can access specific services. This process may vary for each MCO.
- Support Coordinators are responsible for assisting the CCM with obtaining the documentation including prescriptions for requesting prior authorization of medically necessary services.
- Support Coordinators should also coordinate assistance with Medicaid Managed Care Case Management (MMCCM), the MCO Prior Authorization Liaison (MCO PAL) and the LDH PAL via phone, e-mail, fax or referral form.

Support Coordination Role - Locating Providers

- Support Coordinators should assist the CCM with locating a provider contracted with their MCO.
- Resources for locating in-network providers include:
  - Online Provider Directory at myplan.healthy.la.gov.
    - Select Choose > Find a Provider.
    - Choose between Medical and Behavioral Health Providers.
    - 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.).
  - Call the Member Services Line at each MCO to locate a provider in their network *(Medicaid Managed Care Appendix B)*
  - Access MCO's website to identify contracted providers *(Medicaid Managed Care Appendix B)*

What if a provider is not available?

- 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 must fax the Referral to Medicaid Managed Care Case Management (MMCCM) form *(Medicaid Managed Care Appendix Q)* within 3 days of the date of service request to get assistance from the MCO with locating a provider.
- If the MCO is unable to locate a willing provider within 10 days of the Referral to MMCCM, the SC should submit a referral to the LDH PAL - Medicaid Managed Care Member using *Medicaid Managed Care Appendix S.* LDH will forward the referral to the MCO requesting notification upon resolution.

Support Coordination Role - Switching providers

- Support Coordinators are responsible for assisting CCMs with switching service providers.
- Support Coordinators should send a Referral to Medicaid Managed Care Case Management form *(Medicaid Managed Care Appendix Q)* to inform the MCO of the member's desire to change providers.
- Members have the right to change providers at any time; however, approved authorizations are not transferred between agencies. If a member elects to change providers within an authorization period, the current agency must notify the MCO of the member's discharge, and the new agency must obtain their own authorization through the usual authorization process.
- If a member is being involuntarily discharged, they should receive a written notice and appeal rights from the provider. SCs should contact the MCO PAL if the provider fails to provide a discharge notice.

Support Coordination Role - Communication

- Support Coordinators should maintain communication with Medicaid Managed Care Case Management through submission of the PA and the final determination.
- If the service authorization is denied, the support coordinator should assist the CCM with obtaining the required documentation and ensuring that the documents are submitted to the MCO.
- Support Coordinators should assist the CCM throughout the appeal process, if they choose to appeal.

*See Medicaid Managed Care Appendix T-1, T-2, T-3 for timelines.

Support Coordination Role - Communication

- Support Coordinators should send a referral to Medicaid Managed Care Case Management *(Medicaid Managed Care Appendix Q):*
  - to make a referral for a needed service.
  - a CCM is requesting a change in schedule.
  - a prior authorization is about to expire and a renewal is needed.
  - a CCM wants to choose a new provider.
  - a CCM has selected a new provider.
  - a prior authorization has expired.
  - a provider cannot be located to submit a request for prior authorization.
  - a provider is not providing services at the times the member requested.
  - a provider is not providing the amount of services as prior authorized.
  - a CCM was placed on a waitlist.

Support Coordination Role - Communication

- Support Coordinators should send referrals to the LDH PAL for Medicaid Managed Care Member *(Medicaid Managed Care Appendix S)* if:
  - The SC has not received an approval within 60 days from the Choice of Provider date and the MCO was unable to resolve the issue.
  - The SC submitted a Referral to Medicaid Care Case Management (MMCCM) and the MCO was unable to resolve the below issue within 10 days of the Referral to MMCCM:
    - The SC has not received a notice of approval from the MCO for the renewal and the previous PA expired.
    - The SC has been unable to find a provider that is willing to submit a request for a PA. (Note: The MCO is contractually obligated to find a provider within 10 days. LDH will reach out to the MCO when a PAL referral is received to ensure this contractual obligation is met.)
    - A provider is not providing the amount of services as prior authorized, or a provider is not providing services at the times the beneficiary requested.

*If the PAL referral is sent to LDH, for a MCO member, LDH will forward the referral to the MCO requesting notification upon resolution.

Support Coordination Role – Questions and Issues

- All questions regarding the Medicaid Managed Care Program PAL procedures should be filtered through Kim Willems at SRI (225-767-0501 or ksalling@statres.com) to forward to LDH.
- Issues with the Medicaid Managed Care Program communication process should be filtered through Kim Willems at SRI and shared with LDH as well.

Part 3

COVID-19 Exceptions

COVID-19 Exceptions

- As many of the individuals we serve in the EPSDT programs are medically compromised, we have asked for some exceptions in order to minimize the risk to them while still serving them and meeting their needs.

COVID-19 Exceptions

- Support Coordinators will be allowed to utilize telehealth or telephone contact in place of face-to-face initial home visits, quarterly reassessments, and in-home annual assessments. **The beneficiary and the legal guardian must be present to conduct an initial/annual CPOC or quarterly visit.**
- Telehealth is the preferred contact method; however, if the beneficiary does not have access to Skype, FaceTime, etc., telephone contact is acceptable.
- If the Support Coordinator needs to use this exception, the SC must document the reason the exception is being used on the service log. Face-to-face visits can still be conducted.

*PLEASE BE AWARE THAT THESE CHANGES ARE ONLY AVAILABLE DURING THE CORONAVIRUS PANDEMIC EVENT.

COVID-19 Exceptions

- Current supporting formal information assessments may remain in place through the duration of the COVID-19 event. Formal information will include medical, psychological, pharmaceutical, social, and educational information, and information from OCDD. Examples of formal information include the child's individualized educational plan (IEP) and other assessments by professionals, such as EPSDT-PCS Form 90s, Home Health Plans of Care, evaluations by Louisiana Rehabilitative Services (LRS), Special Education Evaluations, behavior plans, psychological evaluations, etc.
- If the Support Coordinator needs to use this exception, the SC must document in the CPOC the barriers to obtaining the current formal information document, strategies to obtain and attempts made.

*PLEASE BE AWARE THAT THESE CHANGES ARE ONLY AVAILABLE DURING THE CORONAVIRUS PANDEMIC EVENT.

COVID-19 Exceptions

- CPOCs are allowed to be completed without beneficiary/legal guardian signatures through the duration of the Covid-19 event. The beneficiary and the legal guardian must be present at the CPOC meeting and the SC must clearly document who was present under Planning Participants and on the service log.

*PLEASE BE AWARE THAT THESE CHANGES ARE ONLY AVAILABLE DURING THE CORONAVIRUS PANDEMIC EVENT.

COVID-19 Exceptions

- Agencies must continue tracking prior authorized services.
- If a service is put on hold due to the COVID-19 event, the SC should enter an Interim Comprehensive Plan of Care (CPOC), mark the service need as on hold (Other – Explain Next Page), and document in Additional Info that the service is on hold due to the COVID-19 event.

*PLEASE BE AWARE THAT THESE CHANGES ARE ONLY AVAILABLE DURING THE CORONAVIRUS PANDEMIC EVENT.

COVID-19 Exceptions

- EPSDT-PCS Informational Bulletin 20-9 – Revised 9.22.21
- The Louisiana Department of Health (LDH) is temporarily changing qualifications for providers of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) personal care services (PCS) **during the COVID-19 health emergency**.

1. A Legally Responsible Relative may be a temporary DSW **if there is absence of agency DSW staff.** Legally responsible relative is defined as the legal guardian, curator, tutor, or other legal custodian by law or custody order (i.e. power of attorney).
2. Beneficiaries and DSWs may live in the same house.
3. Fee-for-service or managed care organization (MCO) approval for these services will be required. Requests will be reviewed on a case-by-case basis. **The provider must have approval from LDH or the MCO.**

Questions/Comments

- Questions and Answers will be sent out with the Training Module.
- Contact Info
  - Kim Willems
  - Statistical Resources, Inc. (SRI)
  - E-mail: ksalling@statres.com
  - Phone: 225.767.0501
  - Fax: 225.767.0502