



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. (This will be included as part of the 16 hours of orientation training.)
- As part of the 40 hours of annual training for existing support coordinators, trainers and supervisors.
- As reference material for support coordinators and supervisors.



Documents Required For Training

- EPSDT – Targeted Population Support Coordination Training Handbook & Appendices
- EPSDT Training Module –
 - EPSDT - Part 1
 - Medicaid Managed Care - Part 2

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 information in more detail than is provided in this presentation.



EPSDT

- **E**arly and
- **P**eriodic
- **S**creening,
- **D**iagnostic, and
- **T**reatment



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 developmental disabilities and/or multiple or chronic medical needs.



Participant Eligibility

- **Individuals on the Developmental Disabilities Request for Services Registry (DD RFSR) or all EPSDT participants if medically necessary,**
AND
- **Under the age of 21,**
AND
- **Are Medicaid Eligible.**

*Refer to *Appendix P* and page 5 of the EPSDT Targeted Population Support Coordination Training Handbook for additional criteria.



How to Access Support Coordination

- Individuals on the Developmental Disabilities Request for Services Registry (DD RFSR) are notified of the availability of Support Coordination.
- If they wish to participate, they are sent a Freedom of Choice (FOC) form to choose a Support Coordination Agency.
- Individuals may elect to receive or discontinue these services at any time. To access the services, they may call SRI at 1-800-364-7828 and request Support Coordination for EPSDT.



Services Available to EPSDT Support Coordination Participants

- All medically necessary Medicaid services.
- Services through the Louisiana Developmental Disabilities services system, administered by Human Services Districts and Authorities.
- Services through the school system or in Early Childhood Education programs.



Medicaid Services

- For a complete listing of Medicaid services, consult the **Medicaid Services Chart** (*Appendix B*) in the Handbook or via the website:
http://dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf
- The EPSDT-Targeted Support Coordination Training Handbook also provides detailed information about specific services.



Medicaid Services for Individuals Under Age 21

- Psychological evaluations and therapy
- Psychiatric residential care
- Medical, dental, vision and hearing screenings and care
- Audiology services
- Speech and language evaluations and therapies
- Occupational therapy
- Physical therapy
- Pediatric Day Health Care (PDHC)
- Applied Behavioral Analysis (ABA)



Medicaid Services for Individuals Under Age 21

- Personal Care Services (PCS)
- Home Health Services
- Extended Home Health Services (EHH)
- Hearing aids and supplies needed for them
- Eyeglasses and/or contact lenses
- Nutritional supplements needed for growth or nourishment
- Diapers
- Any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice



Important Information about Medicaid Services

- Through Medicaid, *individuals under age 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 as part of the state's Medicaid program.



Important Information about Medicaid Services

- No generally fixed limits - Participants under age 21 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.
- 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.



Important Information about Medicaid Services

- All Medicaid participants will have a MCO for Transportation Services.
- All Medicaid participants will have a 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.
- Chisholm Class Members can opt-in to a MCO or stay in Legacy Medicaid for their physical health services. More information on opting-in is provided on slide 152.



EPSDT Screening Exams and Checkups

- Medicaid participants under the age of 21 are eligible for checkups ("EPSDT screening") from physicians.
- These checkups include: a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; and vision, hearing and dental screenings.
- They are available both on a regular basis, and whenever additional medically necessary health treatments or services are needed.
- There are no limits on the number of visits that are **medically necessary** for the individual's condition.



Interperiodic Screen

- An **interperiodic screen** can be obtained whenever one is requested by the parent or recommended by a health, developmental, or educational professional (including a Support Coordinator), who comes into contact with the child outside of the formal health care system in order to determine a child's need for health treatment or additional services.

For Legacy Medicaid: 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 participants 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.



Home and Community Based Waivers for People with Developmental Disabilities

- New Opportunities Waiver (NOW) – comprehensive home and community based services for individuals 3 years of age or older meeting required medical and financial criteria.
- See Appendix D-1.
- Supports Waiver – for individuals age 18 or over who meet required medical and financial criteria. Services are specific activity focused rather than continuous custodial care.
- See Appendix D-3.

Home and Community Based Waivers for People with Developmental Disabilities



- Residential Options Waiver (ROW) – Offers a choice of expanded home and community based services for individuals of all ages meeting required medical and financial criteria.
- See Appendix D-4.
- Children’s Choice Waiver – a limited package of home and community based services for children under the age of 21 meeting required medical and financial criteria.
- See Appendices C and D-2.



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 \$16,410 per year and can be used for medical care, home and vehicle modifications, caregiving assistance and support, and other specialty services.
- Child's name is taken off the Developmental Disabilities Request for Services Registry.
- Note: Children who reach their eighteenth birthday and choose to no longer attend school may transition to the Supports Waiver anytime between their eighteenth and their twenty-first birthday.



Children's Choice

- For more information about the Children's Choice Waiver, refer to Appendix D-2 "Fact Sheet on Children's Choice Waiver" and Appendix C "Frequently Asked Questions" in the Handbook.



Behavioral Health Services

Chisholm class members are enrolled in a MCO for specialized behavioral health services, including:

- Psychiatrist
- Individual, family, and group therapy
- Behavioral Health Rehab
- Applied Behavioral Analysis
- Assertive Community Treatment
- Functional Family Therapy
- Homebuilders
- Multi-Systemic Therapy
- Substance abuse treatment
- Psychiatric hospital
- Psychiatric Residential Treatment Facility
- Case conference

*If a Chisholm Class Member is enrolled in the Coordinated System of Care (CSoC) most of their specialized behavioral health services will be accessed through Magellan.



Behavioral Health Services

Behavioral Health Rehabilitation (BHR) services include:

- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation (PSR)
- Crisis Intervention (CI)
- Therapeutic Group Home
- Crisis Stabilization (CS).

Each MCO's prior authorization unit must approve CPST and PSR services.

*CSoc enrollees will access these services through Magellan.



School-Based Behavioral Health Services

- **Evidenced Based Practices such as:**
 - Assertive Community Treatment (ACT)
 - Family Functional Therapy
 - Multi-Systemic Therapy



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 (the prescription may be included as a recommendation of ABA in the CDE)

Applied Behavioral Analysis (ABA)

- If a participant wants to see if they qualify for ABA, contact the participant's MCO and complete a referral for a Clinical Diagnostic Evaluation (CDE). The CDE will be authorized by the participant's MCO.
- ABA is managed through the Medicaid Managed Care Program for all participants. Contact the participant's MCO to get a list of ABA providers credentialed with the MCO.
- If the recipient needs a CDE to be placed on the ABA waitlist, contact the participant's MCO to get a list of CDE providers. You can place the service need for ABA on hold by marking it as "other – explain next page" and add the CDE as a service need. Once the participant has a CDE completed and is found eligible for ABA, PA tracking for ABA will resume.
- If the recipient is placed on a waitlist for ABA continued PA tracking would not be required *after* you confirm the waitlist placement with the provider and complete a Referral to the Medicaid PAL to notify them of the waitlist placement.

Applied Behavioral Analysis (ABA)



- For more information on ABA contact the participant's MCO (*Medicaid Managed Care Appendix B*) or LDH directly at 1-844-423-4762 and refer to pages 12-13 of the EPSDT SC Handbook.



Coordinated System of Care (CSoC)

- CSoc helps Louisiana's at-risk children and youth who have serious behavioral health challenges and their families. It offers services and supports that help these children and youth return to or remain at home while they are being helped.
- The goal of the CSoc is to keep children:
 - At home
 - In school
 - Out of child welfare
 - Out of the juvenile justice system



Coordinated System of Care (CSoC)

The parent or primary caregiver can make a referral to CSoC by calling the participant's MCO for a brief screening.

- If the individual screens positive on the brief screening, the MCO will refer them to Magellan. Magellan will make a referral to have an independent full CANS assessment conducted by a certified provider.
- Parents/caregivers and family members have a key role in CSoC.
- Every youth and family in the CSoC will be enrolled with a Wraparound Agency (WAA) and will work with a wraparound facilitator who coordinates their care. The WAAs develop a single plan of care and provide lots of help for children in the CSoC.
- CSoC also has Family Support Organizations (FSO) to help families. The FSO provides Parent and Youth Support and Training and makes sure families are involved and have a voice in their care.



Coordinated System of Care (CSoC)

- Children and youth in out-of-home placement or at risk of out-of-home placement who are enrolled in the Coordinated System of Care (CSoC) may receive these **additional** services:
 - Youth Support and Training
 - Parent Support and Training
 - Independent Living Skill-Building Services
 - Short-Term Respite



Personal Care Services

- Tasks that are medically necessary as they pertain to an EPSDT eligible's physical requirements when cognitive or physical limitations necessitate assistance with eating, bathing, dressing, personal hygiene, and bladder or bowel requirements.
- PCS **does not include medical tasks** such as medication administration, tracheotomy care, feeding tubes or indwelling catheters. Assistance with these tasks can be covered through Medicaid's Home Health program.
- 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 **no longer required** to be in the home while services are being provided to children.



How do I find a PCS provider?

- A list is available through the Medicaid website at www.medicaid.la.gov, click Locate a Provider, Personal Care Services, and the region or parish where the participant lives. Another website address to find a provider is: https://www.lamedicaid.com/provider_demographics/provider_map.aspx
- Assistance is also available by calling the Specialty Care Resource Line toll free at 1-877-455-9955 or TTY at 1-877-544-9544.

*For participants with a MCO for their physical health services refer to Slide 167-169.



What if a PCS provider is not available?

- If you cannot find a PCS provider from the list of providers on the LDH website, which is willing to submit a prior authorization request, **call the LDH program staff line at 1-888-758-2220.**
- 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.
- **LDH will take all reasonable and necessary steps to obtain a provider who is willing to submit a prior authorization request within ten days.**

*For participants with a MCO for their physical health services refer to Slide 169.



What if a PCS provider cannot find staff?

- The support coordinator must notify the Medicaid PAL and LDH Program Staff Line if the provider is unable to find staff after services have been approved. This shall be documented in the case record.
- The support coordinator should assist the family in finding another provider agency with available staff from the LDH website's list of providers.
- LDH will take all reasonable and necessary steps to obtain a provider who can staff the approved services within ten days.

*For participants with a MCO for their physical health services refer to Slide 173-174.



How is PCS authorized?

- Personal Care Services must be prior authorized by DXC.*
- The provider must complete a Social Assessment form, a daily time schedule and develop a plan of care.
- A physician 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 participant can receive.
- The Support Coordinator should assure that the physician has all critical information before the services are prescribed.
- All PA requests should include necessary documentation to support the medical necessity of the request.

*For participants with a MCO for their physical health services, PCS is prior authorized by the MCO. See slide 166.



Extended Home Health Services

- Skilled nursing services are available for medically necessary home care that requires at least three hours of nursing care per day.
- Home Health agencies can also provide physical, occupational, and speech therapy in the home if this is medically necessary.
- Home Health Services for children and youth are not limited in terms of frequency or duration.
- A physician must order this service, and Extended Home Health Services must also be prior authorized.
- Needs for less than three hours of nursing care a day can be prescribed by a doctor and obtained without prior authorization. If a provider cannot be found notify the LDH program staff line at 1-888-758-2220. LDH must take all reasonable steps to find a willing and able provider within ten days.



EPSDT PCS vs. Home Health Services

Please refer to Appendix E in EPSDT-
Targeted Population Support
Coordination Training/Handbook



What if a Home Health provider is not available?

- If you cannot find a Home Health provider from the list of providers on the LDH website, which is willing to submit an authorization request (including in-home speech, occupational or physical therapy), call the **LDH program staff line at 1-888-758-2220**.
- 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.
- **LDH will take all reasonable and necessary steps to obtain a provider who is willing to submit a prior authorization request within ten days.**

*For participants with a MCO for their physical health services refer to slides 169.



What if a Home Health provider cannot find staff?

- The support coordinator must notify the Medicaid PAL using the Referral to Medicaid PAL form (Appendix S) if the provider is unable to find staff after the service has been approved. This shall be documented in the case record. Medicaid PAL contact info is on slide 124.
- The support coordinator should assist the family in finding another provider agency with available staff from the LDH website list of providers.

*For participants with a MCO for their physical health services refer to slides 173-174. MCO PAL contact info is on slide 124.



Pediatric Day Health Care

- Serves medically fragile individuals under the age of 21, including technology dependent children, who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition.
- These facilities offer an alternative 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 recipient'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. (b) Respiratory care. (c) Physical, speech, and occupational therapies. (d) Assistance with activities of daily living. (e) Transportation services. (f) Education and training.
- Before and after school care (as a substitute for child care) is not a covered service because PDHC is designed to be offered for either half a day (six or less hours) or a whole day (more than six hours; not to exceed twelve hours in a day). A child may receive PDHC before or after school for less than six hours if it is medically necessary.



Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services

- For Medicaid to cover these services through a school or in an early childhood educational setting, they must be part of the child's IEP or IFSP.
- For Medicaid to cover these services through a provider outside of an educational setting, they do not need to be part of the IEP or IFSP, but must be prior-authorized by Medicaid.



Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services

- Therapies can be provided at school, in an early childhood educational setting, in the home, in an outpatient hospital, in a free-standing rehabilitation clinic, or in a combination of settings.
- The Support Coordinator helps the family to determine the setting in which the child will receive the greatest benefit making the appropriate referral and coordinating the days and times of this service with other services the participant is receiving.



What if a Physical Therapy, Speech Therapy, or Occupational Therapy provider is not available?

- If you cannot find a Physical Therapy, Speech Therapy, or Occupational Therapy provider from the list of providers on the LDH website, which is willing to submit an authorization request, call the **LDH program staff line at 1-888-758-2220**.
- 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.
- **LDH will take all reasonable and necessary steps to obtain a provider who is willing to submit a prior authorization request within ten days.**

*For participants with a MCO refer to Slide 169.



Medical Equipment and Supplies

- Participants 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 medical condition. It also includes necessary dietary or nutritional assistance if they are needed because of a medical problem.
- Medical Equipment and Supplies must be prescribed by a physician and prior authorized.



Medical Equipment and Supplies

- Incontinence supplies for children ages 4 through 20
- Based on medical necessity, pull-ups, diapers, and liners/guards may be approved.
- Refer to Appendix R-1 for more information and the prescription request form for disposable incontinence supplies.



Medical Equipment and Supplies

- The Medicaid prior authorization unit* may approve **less expensive items** that it believes will meet a participant's needs. If so, the notice of denial should identify the items.
 - The participant 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 participant and the provider to see if the less costly item identified will work, and help the participant 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 participant wants that help.

*or the MCO prior authorization unit if the participant has a MCO for their physical health services.



Transportation

- Even if Medicaid recipients are not covered under the Medicaid Managed Care Program for other services, their transportation needs would be authorized and paid for under their MCO. They cannot opt-out of the Medicaid Managed Care Program for transportation.



Transportation

- Non-emergency medical transportation (NEMT) is provided for Medicaid recipients to and/or from a provider for a Medicaid covered service. All participants can access this service through their MCO (*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

- The role of the Support Coordinator is to assist the family in arranging transportation services for the participant.
- Transportation must be provided in all parishes and to all eligible enrollees. If there is a need for special arrangements, such as lift-equipped transportation, the MCO must insure that such arrangements are made promptly so that the enrollee can obtain the medical services they need.
- The phone numbers to the MCOs can be found in *Medicaid Managed Care Appendix B*.



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 enrollee’s friend or family member to take them to medical appointments when certain conditions are met. To assist someone you are serving that may benefit from this arrangement contact the enrollee’s MCO (*Medicaid Managed Care Appendix B*).



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** (toll free) at:
1-877-455-9955 or TTY 1-877-544-9544.

*For participants with a MCO, refer to *Appendix F* and contact the MCO at the numbers listed.



Other Medicaid Services Not Listed

Even if a service is not on the Medicaid services chart or available through a referral from the Specialty Care Resource Line, 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 recipient who is under age 21. Persons under age 21 are entitled to receive all medically necessary equipment or items that Medicaid can cover. This includes many items that are not covered for adults. These services may be subject to any restrictions allowable under Federal Medicaid law.



Non-Medicaid Services

- Many non-Medicaid sources of services and support are available, such as:
 - OCDD Human Service Districts and Authorities
 - Flexible Family Funds (Cash Subsidy)
 - Community Support Teams
 - Individual and Family Supports
 - Support Coordination

*Refer to the EPSDT Targeted Population Support Coordination Training Handbook pages 23-24 and Appendix G.



Non-Medicaid Services

- Office of Behavioral Health Services
 - Local Governing Entities – Community Behavioral Health Clinics
 - CART (child/adolescent response teams)

*Refer to the EPSDT Targeted Population Support Coordination Training Handbook pages 24-25 and Appendix I.



Non-Medicaid Services

- School and Early Childhood Education services
- Other community services

*Refer to the EPSDT Targeted Population Support Coordination Training Handbook pages 25-27.



What Happens at Age 21?

- The participant 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 offerings for adults.
- The support coordinator should be aware of available services and make arrangements to transition the participant 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.
- The support coordinator should begin making arrangements for transition at least 6 months prior to the participant's 21st birthday.



Age 21, cont'd

Available services may include:

- OCDD services, including (in addition to those listed above) extended family living, supported independent living, and vocational and rehabilitative services.
- Medicaid Long Term-Personal Care Services (LT-PCS). Participants 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. Additional information can be obtained about LT-PCS by calling **1-877-456-1146**.
- OAAS - Community Choices Waiver and Adult Day Health Care Waiver services 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).
- Louisiana Rehabilitation Service may provide assistance with services needed to pursue short or long-term employment goals including higher education.



Medicaid Services Chart

- The Medicaid Services Chart is *Appendix B* in the EPSDT Target Population Support Coordination Training/Handbook.
- If the Specialty Care Resource Line does not have providers listed, call the contact person listed on the Medicaid Services Chart. Call the LDH Staff Line for providers if the service contact person is unable to assist at 1-888-758-2220.

*For participants in the Medicaid Managed Care Program for more than transit and mental health their MCO's contacts should be used rather than those in the Chart. Refer to slides 166 and 168. Since the MCO must cover at least as much as Legacy Medicaid, the Chart can still be helpful reference.



Support Coordinator Responsibility

After linkage is made:

- Validate Medicaid Eligibility through MEVS/REVS or e-MEVS at the beginning of every month.
- If the participant 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 pages 89-90).



Intake

- Contact the participant within 3 working days of linkage.
- Determine if the participant is a “competent major.”
 - If there is no record of interdiction and the participant is able to express his/her preferences, the Support Coordinator must speak directly to the participant until an Authorized Representative Form (*Appendix U*) is on file should they choose to have an Authorized Representative.
 - If the competent major has not been interdicted but is unable to express his/her preferences, the Support Coordinator must document this in the CPOC and obtain an Authorized Representative Form (*Appendix U*) to allow a caregiver to be the EPSDT contact and sign for them.
- Determine if the participant accepts Support Coordination and agrees with the requirements of the face-to-face visits.
- The **Case Management Choice and Release of Information Form (FOC)** can be used to obtain all plans, evaluations, and assessments that OCDD has developed or used in connection with its determination that the participant is eligible for services through the developmental disability services system. The information should be useful in the planning process. (*Appendix N shows a sample of the form you will receive upon linkage.*)



At the Face-to-Face Visit

- Inform participants of:
 - Support Coordination Responsibilities and Participant Rights and Responsibilities (*Appendix K*)
 - HIPAA & Confidentiality
 - Appeal Process (*Appendix L and Medicaid Managed Care Appendix F*)
 - Complaint Process for filing a report against support coordinators and/or Providers (*Appendix M*)
 - Health Standards Complaint Line, 1-800-660-0488 (*Appendix K*)
 - The Medicaid Managed Care Program Assistance Line, 1-888-342-6207, which can be used to make a complaint against a MCO. Complaints against MCOs can also be e-mailed to healthy@la.gov.
 - Review Medicaid Services Chart (*Appendix B*) and for participants enrolled in the Medicaid Managed Care Program review information on plan services (*Medicaid Managed Care Appendix B, Slides 166-169*)
 - Availability of formal and non-formal services



At the Face to Face Visit

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

**REVIEW THIS INFORMATION AS OFTEN AS IS
NECESSARY**



Assessment

- Is the process of compiling 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 participant and may also include information gathered from talking to friends and extended family.



Assessment

- Assist the participant in arranging professional evaluations and appointments including activating examination/diagnosis/treatment loop such as EPSDT screenings and immunizations and follow-up evaluations.
- Must begin within 7 calendar days of the referral and a face-to-face in-home visit must be completed within 10 calendar days of the referral.



Comprehensive Plan of Care (CPOC)

- The CPOC is developed based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the participant.
- The CPOC must be outcome oriented, individualized and time limited.



Comprehensive Plan of Care (CPOC)

- The CPOC is developed through a collaborative process and **MUST** be completed in a face-to-face meeting with the participant and others they wish to be present such as family, friends or other support systems, the support coordinator, and others that know the participant best.
- **Everyone** present at the meeting must sign the CPOC Participants Signature Page in the Planning Participants box.



Comprehensive Plan of Care (CPOC)

- Service needs must be mutually agreed upon strategies to achieve or maintain the desired outcomes which rely on informal, natural community supports and appropriate formal, paid services.
- Use all assessment and intake information to identify the participant's needs and identify those additional services that will meet the participant's unmet needs.
- Assist the participant to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes.
- Document services the participant is currently receiving.



Comprehensive Plan of Care (CPOC)

- Explain Medicaid services using the most current **Medicaid Services Chart** (*Appendix B*) with special emphasis on DME, EPSDT-PCS, Home Health and EPSDT Screening Exams.
- The most current Medicaid Services Chart can be found
 - Online at:
http://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf
 - *Appendix B* in the Handbook
- Also available for your use is a PCS and Home Health Chart (*Appendix E*) that will assist in identifying the need for these services.

*Note: PCS can be approved for more than 4 hours per day. The amount of hours approved is based on what is documented as medically necessary and covered through this program; there are no set limits. A parent or adult caregiver is **no longer required** to be in the home while services are being provided to children.*



Comprehensive Plan of Care (CPOC)

Refer to the LSCIS CPOC (*Appendix O*) for review:

The content of the LSCIS CPOC includes:

- Section 1 – Demographics/Contact Information
- Section 2 – Medical/Social/Family History
- Section 3 - CPOC Service Needs and Supports
- Section 4 – Additional Information/Participants
- Section 5 – CPOC Approval
- Typical Weekly Schedule (Paper Form)



Comprehensive Plan of Care (CPOC)

Section 1 – Demographics/Contact Information

- Include information about parent or legal guardian and relationship.
- If the participant is a competent major address if they can direct his or her own care.
- Fill in all blanks or provide explanations if information is unknown.

LSCIS CPOC Section 1

Demographics/ Contact Information

LSCIS Client Data Form

V 4.25

Site: 0299030

[Find Client](#) [Add Client](#) [Find Services](#) [Add Services](#) [Agency Info.](#) [Provider Numbers](#) [Delete Voided Ticket](#)
[Modify/Delete Case Number](#) [Reviewable CPOCs](#) [Reports](#) [Download Site Data](#) [Electronic PA](#) [Request Deleted Elec. PA's](#) [Reassign Case Load](#)
[Denied CPOCs](#)

Case #: 00001 Name: Last Doe First John MI L Target: ETP Vent. Dep.: DCFS/OCS: S. C. MAH

Physical MCO Agency:

Behavioral MCO Agency:

Edit

Print

[Contact Information](#) [Demographic Information](#) [Closure Information](#) [Pa History](#) [CPOC History](#) [Tracking History](#)

Client SSN: 123-45-6798 Medicaid ID: 0123465790123

This Medicaid Number does not match the medicaid number on the most recent PA (9070545607947)

Parish: 24 IBERVILLE Region: 02

Date of Birth: 01/01/2010 Age: 9 / Child

Case Open: 02/03/2015

Sex: 2 Female Race: 1 White

Legal Status: 2 Minor

Is able to direct his/her own care:

ID: not ID Adaptive Functioning: Moderate

Residential Placement: 11 OCS Foster Care

Number of ID/DD/Special Needs in Home (excluding recipient): 0

Names:

Current Education/Employment: 06 Special Education Only

Non-Chisolm reason:

ICD10 Diagnosis: F88. OTHER DISORDERS OF PSYCHOLOGICAL I

Edit



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

- Summarize important aspects of the person's health, behavioral and/or psychological concerns. Any pertinent information about the individual that can be provided by the family or gathered from formal information documents should be documented.
- If any information is unknown, state that it's unknown.
- When designing the goals and objectives of the CPOC, it is important to take into account the strengths and weaknesses of the informal/natural supports. It is the Support Coordinator's job to look at and respond to the needs of the participant; however, often the family's needs have a direct impact on the participant's needs.



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

- If there is only sketchy information available in any health status area, remember the participant is eligible for screenings, which can help to determine his/her health needs. It is the Support Coordinator's responsibility to help the participant access those screening services.
- It is important to remember that psychological and behavioral services are available for the participant and should be offered. If it seems a behavioral support plan would benefit the participant, but there is not one in place, refer the participant for this service. Information gathered from the psychologist's assessment could prove invaluable in the development of the CPOC.



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

■ Past

- Prenatal Health
- Nature and cause of disability
- Age of diagnosis and made by whom
- Any early intervention services
- Past medical history, surgeries, hospitalizations
- Any placement history outside of current placement
- Why is EPSDT SC being requested? 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?



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

■ Present

- Names and age of household members
- Primary caregiver and natural supports
- Address mom and dad and if they provide any natural or financial support
- Is the home owned or rented?
- Does the home environment meet their needs?
- Access to transportation and community
- Source of household income



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

■ Medical Diagnoses

- 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 doctor’s names, their specialty, how often they see them, and last visit/next visit to identify if they overdue for a visit.
- List all medications and what they are prescribed for.
- 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?
- Ambulation
- Communication
- Vision
- Hearing
- Toileting needs
- Dietary needs



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

■ Psychiatric/Behavioral

- Address behaviors at both home and school.
- What behaviors do they have / what does it look like?
- Any triggers?
- How often does it occur?
- What strategies are used to deal with behaviors?
- What behavior services are received and were offered?



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

■ Evaluation/Documentation

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

LSCIS CPOC Section 2 – Medical/Social/Family History

Contact Information
 Demographic Information
 Closure Information
 Pa History
 CPOC History
 Tracking History

Cpoc History

| Cpoc Type | Support Coordinator | Submit for review by LDH | Submit Date | Approval Status | Reviewer | Begin Date | End Date | Q.R. Date | Edit | Void | Print |
|-----------|---------------------|--------------------------|-------------|-----------------|----------|------------|------------|-----------|------|--------------------------|-------|
| Interim | MAH Marcia Hardy | <input type="checkbox"/> | | | | 02/10/2018 | 02/09/2019 | | | <input type="checkbox"/> | |

2. Medical/Social/Family History
 3. CPOC Service Needs and Supports
 4. CPOC Participants
 5. CPOC Approval Information
 CPOC Quarterly Review
 Approval Denial Notes History

PAST: Pertinent Historical Information

PRESENT: Describe Current Living Situation and Natural Supports:

HEALTH STATUS

Physician: Last Appointment Date :

Immunization Current:

Medical Diagnoses and Concerns/Significant Medical History (Include findings of last physical):

Psychiatric/Behavioral Concerns:

Dates of Evaluations/Documentation used to develop this CPOC

Social Evaluation

Psychological Evaluation

Psychiatric Evaluation

Special Education Eval.

Current IEP

Behavior Management Plan

Home Health Plan of Care

Form 90 or Medical Records

Pediatric Day Health POC

SOA

Expiration:

Permanent:

Other

Describe:



Comprehensive Plan of Care (CPOC)

Section 3 - CPOC Service Needs and Supports

- Identify all goals and the support strategy needed to meet the goals (Who, What, When, Where & How Often). Space is available in section 4 – Additional Information to more clearly identify each need.
- Identify all services the participant is currently receiving (Medicaid and non-Medicaid) and those that are requested, clearly identifying each and the amounts approved.
- Identify services for the participant that require prior authorization (PA).



Comprehensive Plan of Care (CPOC)

Section 3 - CPOC Service Needs and Supports

- Make sure to select the appropriate service need from the drop down box – especially for BHR and ABA so LSCIS knows to make any tracking logs for those services Medicaid Managed Care Program tracking logs.
- Check the appropriate box of who will be providing/funding the service need – Medicaid, School, Community, Family (if through private insurance or if family will pay for out of pocket), or OCDD.
- Assure and document at the time of the CPOC meeting the participant/family 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.
- List every service need separately. (DME products for a specific task can be grouped together *if* all of the products are ordered from the same provider with the same PA service dates like DME/Wound Care for gauze, tape, gloves, saline.)



Comprehensive Plan of Care (CPOC)

Section 3 - CPOC Service Needs and Supports

- List identified service needs such as:
 - School therapies (OT, PT, ST)
 - School Assistive Technology (AT)
 - School Social Worker or Nursing
 - PCS
 - EHH or Skilled Nursing
 - PDHC
 - Community therapies (OT, PT, ST)
 - DMEs (one time DMEs like wheelchairs, hospital beds or weighted blankets and ongoing DMEs like formula, trach supplies, or g-tube supplies)
 - Diapers
 - ABA
 - Home modifications
 - Community Services
 - Redetermination (If SOA expires that CPOC year)
 - OCDD Services (cash subsidy/family flexible fund, family support, respite, or redetermination)
 - Behavioral Health Services (psychiatrist, behavioral medications, social workers, counseling, etc.)
 - Behavioral Health Rehab (Psychosocial Rehab, Community Psychiatric Support and Treatment, Crisis Intervention, Crisis Stabilization)
 - CSoC Services (Wraparound, Peer or Parent Support, Independent Living Skill-Building Services, Short-term Respite)
 - Transition if the participant will be twenty and half years old that CPOC year
 - Needed referrals for doctors (anyone they are overdue for a visit with or any specialist they need a referral to)
 - Any needed evaluations



Comprehensive Plan of Care (CPOC)

■ Section 3 - CPOC Service Needs and Supports

- If a service need is *not* being requested now you have 3 options to explain why:
 - **Carried Over – Resolved:** The service need is no longer an identified need.
 - **Family Does Not Want:** The need for the service has been identified but the participant/family 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 participant/family has plans to request in the near future.
- Always explain your reason in Section 4 – Additional Information.

LSCIS CPOC Section 3 – CPOC Service Needs and Supports

LSCIS Client Data Form V 4.25 Site: 0299030

[Find Client](#) [Add Client](#) [Find Services](#) [Add Services](#) [Agency Info.](#) [Provider Numbers](#) [Delete Voided Ticket](#)
[Modify/Delete Case Number](#) [Reviewable CPOCs](#) [Reports](#) [Download Site Data](#) [Electronic PA](#) [Request Deleted Elec. PA's](#) [Reassign Case Load](#)
[Denied CPOCs](#)

Case #: 00001 Name: Last Doe First John MI Target: ETP Vent. Dep.: DCFS/OCS: S. C. MAH

Physical MCO Agency:

Behavioral MCO Agency:

[Contact Information](#) [Demographic Information](#) [Closure Information](#) [Pa History](#) [CPOC History](#) [Tracking History](#)

CPOC History

| CPOC Type | Support Coordinator | Submit for review by LDH | Submit Date | Approval Status | Reviewer | Begin Date | End Date | Q.R. Date | Edit | Void | Void | Print |
|-----------|---------------------|--------------------------|-------------|-----------------|----------|------------|------------|-----------|-------------------------------------|--------------------------|-------------------------------------|--------------------------------------|
| Interim | MAH Marcia Hardy | <input type="checkbox"/> | | | | 02/10/2018 | 02/09/2019 | | <input type="button" value="Edit"/> | <input type="checkbox"/> | <input type="button" value="Void"/> | <input type="button" value="Print"/> |

[2. Medical/Social/Family History](#) [3. CPOC Service Needs and Supports](#) [4. CPOC Participants](#) [5. CPOC Approval Information](#) [CPOC Quarterly Review](#) [Approval Denial Notes History](#)

Service Needs

| Service Strategy/Description | How was Need determined | Requested by participant/family | If not why not? | Primary Goal | Receiving | Medicaid | School | Community | Family | OCDD | Requires PA tracked by S. C. | Amount Approved | Void | Edit |
|--------------------------------------|-------------------------|-------------------------------------|----------------------|----------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|-----------------|-------------------------------------|-------------------------------------|
| Other (7) APE | IEP | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Other (6) Gastro | Family | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Other (5) ENT | Family | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Other (4) Allergiest | Family | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Other (3) FSA: Samsung tablet | Family | <input type="checkbox"/> | Family does not want | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Diapers (1) Incontinence Supplies | Family | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Other (1) Development Specialist | Family | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Dental Services (1) Routine Check up | Family | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Speech Therapy (1) Communication | IEP | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| OT (1) Motor Skills | IEP | <input checked="" type="checkbox"/> | | Best possible health | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input type="checkbox"/> | <input type="button" value="Edit"/> |
| Other (8) Example to void | Family | <input type="checkbox"/> | Void | Void | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | / | <input checked="" type="checkbox"/> | <input type="button" value="Edit"/> |



Comprehensive Plan of Care (CPOC)

Section 4 – Additional Information/CPOC Participants

■ CPOC Participants

- All individuals and providers present at the CPOC meeting, including the participant and legal guardian, must sign the CPOC indicating they participated in the planning under Planning Participants.
- The participant and/or parent/guardian must sign and date the completed CPOC.
- The support coordinator present at the meeting must sign the CPOC.
- The SC supervisor will sign indicating they completed their review prior to submittal to SRI.



Comprehensive Plan of Care (CPOC)

Section 4 – Additional Information/CPOC Participants

■ Additional Information

- An Additional Information section is available to address goal strategies if needed and identify all of the service providers.
- If on a waitlist for PT, OT, ST or ABA and PA tracking is not checked, identify that the waitlist placement was confirmed with the provider and the PAL was notified. Also explain how you will ensure they move up the waitlist.
- 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.



Comprehensive Plan of Care (CPOC)

Section 4 – Additional Information/CPOC Participants

■ Additional Information

- **If any services that typically require PA tracking are not checked as requires PA tracked by SC, document the valid reason why *and* how you will ensure the services continue to be received.** The SC is still responsible for ensuring the services are received and may need to assist with obtaining the prescription or letter of medical necessity, scheduling assistance, choice of provider, etc.
- Valid Reasons for not tracking (refer to page 48 of the Handbook):
 - If the PA is *issued* monthly
 - If the EHH nurse is the person ordering and tracking medical supplies
 - If the participant is on a waitlist (must confirm waitlist placement with provider and notify PAL before untracking)
 - If the MCO does not require a PA for the service (must confirm with provider/MMCCM)
 - 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*)



Comprehensive Plan of Care (CPOC)

Section 4 – Additional Information/CPOC Participants

- Document that the following occurred:
 - Explanation and review of Medicaid Services Chart (*Appendix B*)
 - The Services Available to Medicaid Eligible Children Under 21 Brochure has been provided (*Appendix F*)
 - Referral to EPSDT Screening provider
- Identify how often the goals and support strategies will be reviewed (minimum requirement is quarterly).



Comprehensive Plan of Care (CPOC)

Section 4 – Additional Information/CPOC Participants

- Reminder: Section 4 requires documentation of review of the Medicaid Services Chart; however, the Medicaid Services Chart should also have been reviewed initially during the face to face visit.
- The Medicaid Services Chart should be kept handy and reviewed as many times as necessary during the development of the CPOC.

*For recipients in the Medicaid Managed Care Program for more than transit and mental health their MCO's contacts should be used rather than those in the Chart. Refer to slides 166 and 168. Since the plans must cover at least as much as Legacy Medicaid, the Chart can still be helpful reference.

LSCIS CPOC Section 4 – Additional Information / CPOC Participants

2. Medical/Social/Family History
 3. CPOC Service Needs and Supports
 4. CPOC Participants
 5. CPOC Approval Information
 CPOC Quarterly Review
 Approval Denial Notes History

Planning Participants: Title and Agency Name: Additional Information about Service Needs and Supports:

S. C. has explained that Medicaid will provide medically necessary therapies, in addition to the therapies received at school through the IEP.
 If no why not:

Support Coordinator has reviewed Medicaid Services Chart with the participant and family: If no why not:

Support Coordinator has provided the participant and family with information on Medicaid EPSDT Services: If no why not:

Support Coordinator has provided the participant and family with information on EPSDT Screening Services:
 If not why not:

EPSDT Screening Services requested: If yes referral Date:

Participant Signature Date:

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he or she needs to attain or maintain their personal outcomes. The Support Coordinator will have phone contact with the family/participant at least monthly and meet face to face at least quarterly to assure that the CPOC continues to address the participant's need and that that services are being provided. The CPOC will reviewed by the Support Coordinator at least quarterly and revised annually and as needed. If there are no services to coordinate, the family/recipient has been informed of this and that they can access support coordination at any time until the child's 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry.

Signature of Support Coordinator: S.C. Signature Date: Ready for Supervisor Review:



Comprehensive Plan of Care (CPOC)

Section 5 – CPOC Approval Information

- The support coordinator's supervisor must review the current and prior CPOC, formal information documents, Service Logs, and Quarterly Reviews prior to signing and submitting the CPOC to SRI.
- Make sure all discrepancies are resolved.
- The Support Coordinator must submit the *approvable* CPOC to be received by SRI no later than 35 days from the date of linkage/referral.

NOTE: The CPOC will not transmit unless all required fields are completed. The original signature pages must be kept in the case record.



Comprehensive Plan of Care (CPOC)

Section 5 – CPOC Approval Information

- For initial plans, assessment data (the current formal documents and all assessments/evaluations and supporting documents from the regional OCDD office) and required documents listed on *Appendix X* shall be sent via mail or fax to SRI.
- *Appendix X* shall also be submitted with the required documents for all Special Needs SC cases to SRI.
- The CPOC may be randomly selected for monitoring when the SC supervisor submits it to LDH/SRI for review. The Monitoring Checklist (*Appendix X-2*) and required documents must be received by SRI within two working days.
- The Support Coordinator is responsible for requesting and coordinating all services identified in the CPOC immediately upon completion of the CPOC (date the recipient or parent/guardian signed the approval page) and prior to approval from BHSF/SRI.
- Approval of Medicaid state plan services is through the PA unit, therefore, the Support Coordinator should not await BHSF/SRI approval of the CPOC before making referrals for necessary services.



Comprehensive Plan of Care (CPOC)

Section 5 – CPOC Approval Information

- BHSF/SRI shall review the CPOC to ensure that all notification, information, planning and identification of needed services has been included.
- Any information not completed will result in the CPOC being returned without approval for completion. This will result in a new submit date.
- 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

Contact Information
 Demographic Information
 Closure Information
 Pa History
 CPOC History
 Tracking History

Cpoc History

| Cpoc Type | Support Coordinator | Submit for review by LDH | Submit Date | Approval Status | Reviewer | Begin Date | End Date | Q.R. Date | Edit | Void | Void | Print |
|-----------|---------------------|--------------------------|-------------|-----------------|----------|------------|------------|-----------|------|--------------------------|------|-------|
| Interim | MAH Marcia Hardy | <input type="checkbox"/> | | | | 02/10/2018 | 02/09/2019 | | | <input type="checkbox"/> | Void | |

2. Medical/Social/Family History
 3. CPOC Service Needs and Supports
 4. CPOC Participants
 5. CPOC Approval Information
 CPOC Quarterly Review
 Approval Denial Notes History

I, the Support Coordinator Supervisor, have reviewed all of the listed evaluations/documentation used to develop this CPOC, service logs, and quarterly reviews for identified needs and the status of requested services. The entire CPOC was reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

Signature Support Coordinator Supervisor: Date:

Submit for review by LDH:

Approval/Denial Information

By: Approval/Denial Date:

Approval/Denial Notes:



Comprehensive Plan of Care (CPOC)

Typical Weekly Schedule (Paper Form)

- The 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 participant is currently receiving.
- Include new services the participant is requesting.
- Show when the participant is in school, at home or participating in other activities.



Comprehensive Plan of Care (CPOC)

Typical Weekly Schedule (Paper Form)

- If a prior authorized service is denied and not appealed, or if for any other reason the planned services are not delivered, the schedule should be amended to reflect only services actually put in place.
- If the participant 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.
- This document is kept in the case record.



Coordination of Services

- The CPOC is considered a holistic plan, therefore the Support Coordinator is responsible for coordinating all identified service needs, including paid and unpaid supports as well as non-Medicaid Services.
- Support Coordinators should provide as much assistance as possible to the family to identify and obtain non-Medicaid services (home modifications, respite, financial assistance, etc.) that are identified in the plan.



Coordination of Services

- Support Coordinators should:
 - Give the participant/family a Choice of Providers (unless they are already satisfied with a provider). Lists of providers can be obtained from the Medicaid website and the Specialty Care Resource Line (refer to Slide 33).*
 - Assist the participant in contacting prospective providers and finding out if they are willing to submit prior authorization requests.
 - If none of the providers are able to provide the requested service, call the LDH Program Staff Line at 1-888-758-2220 to report the difficulty.*

*For participants with a MCO refer to slides 167-169.



Coordination of Services

- Support Coordinators should:
 - Have the participant/family list the provider they choose and sign the Choice of Provider Form for EPSDT Medicaid Providers (*Appendix Z*).
 - Make referrals to the appropriate providers (*Appendix Q*).
 - Give the participant 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 family/provider in gathering the appropriate documentation needed to support the request.



Coordination of Services

- Support Coordinators should:
 - Notify the Medicaid PAL if the provider is unable to find staff after the services have been approved.

*For participants with a MCO refer to slides 173-174, 176.



Coordination of Services

- The Support Coordinator will immediately begin to coordinate all identified needed services. **PA tracking begins with the request for the service – not the choice of provider or receipt of prescription.** Once a service is requested:
 - Add the Service Need to the CPOC.
 - For services requiring prior authorization and PA tracking complete the Referral to Provider form (*Appendix Q*) and send it to the chosen provider.
 - *For participants with the Medicaid Managed Care Program refer to slides 172 and use *Medicaid Managed Care Appendix Q* to complete referral to HLCM.
 - Referrals to providers should be made within 3 calendar days of CPOC completion, or within 3 calendar days of the date the family selects the provider* as documented on the Choice of Provider Form (if the date of provider selection is later than the CPOC meeting).

*Or for participants with a MCO, referral to Medicaid Managed Care Case Management should be made within 3 calendar days of the date of service request and again within 3 calendar days of the date of the choice of provider. Only one referral is required if choice of provider is known when the service is requested.



Coordination of Services

- The SC will track all prior authorization requests on behalf of the participant.
- The electronic EPSDT Prior Authorization Tracking Log will document the nature and specific amount of each service being sought, provider and PAL referrals, provider contacts, and information about approval, denial and appeals.



Coordination of Services

- The electronic EPSDT Service Log is used to provide a narrative of activities related to the request for EPSDT services including each activity and contact with the provider, the participant and the PAL.
- 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.



EPSDT Prior Authorization Tracking Log

The electronic **EPSDT Prior Authorization Tracking Log** is an important tool for Support Coordinators. The PA Tracking Log:

- Provides assurance the participant is receiving the services requested (PA should be issued within 60 days of request from date of Choice of Provider).
- Serves as a reminder to contact the provider* if you have not received a copy of the Prior Authorization Request Form.
- Allows you to know at a glance what was/was not approved and the dates.

*and/or the Medicaid Managed Care Case Manager if the tracking log is for a service PA by the MCO.



EPSDT Prior Authorization Tracking Log

- The PA Tracking Log:
 - Serves as a reminder to notify the provider to submit a prior authorization request to assure continuation of services (45-60 days prior to PA end date).
 - *For participants with a MCO, the timeline is 20-60 days prior to the PA end date and you notify the Medicaid Managed Care Case Manager.
 - Provides documentation that appeal assistance was offered/provided to the participant and the Appeals brochure was provided.
 - Serves as documentation of the date the prior authorization request was received.



EPSDT Prior Authorization Tracking Log

- A separate tracking log is completed for each service that requires prior authorization. (Note: Supplies relating to a specific activity may be listed on one log if the provider and PA service dates are the same.)
- A new **Renewal** tracking log is used for each PA cycle after the reminder notice for renewals is sent to the provider. (The date the reminder notice is sent is the date of referral for a new tracking log. Keep the date of service request the same.)
- A new **Change in Service** tracking log is used for changes in existing services (i.e. additional hours of service requested). (Keep the date of service request the same as the previous tracking log.)



EPSDT Prior Authorization Tracking Log

- The log provides space for ongoing tracking information relating to the status of the prior authorization/service including:
 - Type of Service and Amount
 - Date of Request and Date of COP (Choice of Provider)
 - Provider
 - Date of Referral to Provider (within 3 days of date of COP)
 - Required Provider Contacts
 - Referral to PAL (if required)
 - PA Approval and Dates

NOTE: A new Change in Service tracking log is to be initiated for each new choice of provider.



Coordination of Services

- 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 Prior Authorization packet has not been submitted within 35 calendar days, use the Referral to PAL form (*Appendix S*) to notify the PAL for services authorized through Legacy Medicaid only. Also inform the participant about their right to change providers.
- If a Prior Authorization decision has not been received within 60 calendar days, use the Referral to PAL form (*Appendix S*) to notify the PAL. Also inform the participant about their right to change providers.
 - For the Medicaid Managed Care Program use *Medicaid Managed Care Appendix S, S-1 and S-2*.

LSCIS Prior Authorization Tracking Log

LSCIS Client Data Form V 4.25 Site: 0299030

[Find Client](#) | [Add Client](#) | [Find Services](#) | [Add Services](#) | [Agency Info.](#) | [Provider Numbers](#) | [Delete Voided Ticket](#)
[Modify/Delete Case Number](#) | [Reviewable CPOCs](#) | [Reports](#) | [Download Site Data](#) | [Electronic PA](#) | [Request Deleted Elec. PA's](#) | [Reassign Case Load](#)
[Denied CPOCs](#)

Case #: Name: Last First MI Target: Vent. Dep.: DCFS/OCS: S. C.
 Physical MCO Agency:
 Behavioral MCO Agency:

[Contact Information](#) | [Demographic Information](#) | [Closure Information](#) | [Pa History](#) | [CPOC History](#) | [Tracking History](#)

Support Coordinator: Type of Service Requested: Type Of Request: Amount of Requested service: Date of Service Request:
 Date of COP: Provider: Date of Referral to Provider/MMCCM: 15 Day Provider/MMCCM Contact Date: 35 Day Provider/MMCCM Contact Date:
 Date Packet Submitted to DXC/MCO: Date Provider PA Request Packet Received: Not Received: Date of Referral to PAL (Untimely PA Packet Submission): Date of Decision: Date PA Notice Received: Date of Referral to PAL (Untimely PA Notice): Amount of Service Approved:
 PA Begin Date: PA End Date: Service Start Date: PA Issued within 60 Days of Request: NA
 Explanation, if not issued:
 Date Renewal Sent and new tracking started: Date Denial of Service Notice Received:
 Approval/Denial Status: Reason for Denial: Date Appeal Rights Explained: Date Appeal Brochure Provided: Offered to help with appeal Date: Is Client Appealing:
 Request Assistance with Appeal: Date Appeal Sent to LDH: 20 Day Appeal Follow Up: 90 Day Appeal Follow Up: Date of Appeal Decision: Appeal Outcome:
 Notes:

LSCIS Prior Authorization Tracking Log for Medicaid Managed Care Program Services

Medicaid Managed Care Program

Print

Medicaid Managed Care Program

- Contact Information
- Demographic Information
- Closure Information
- Pa History
- CPOC History
- Tracking History

Support Coordinator: ? Type of Service Requested: Type Of Request: Amount of Requested service: Date of Service Request:

Date of COP: Provider: Date of Referral to Provider/MMCCM: 15 Day Provider/MMCCM Contact Date: 35 Day Provider/MMCCM Contact Date:

Date of 2nd Referral to Provider/MMCCM: 2nd 15 Day Provider/MMCCM Contact Date: 2nd 35 Day Provider/MMCCM Contact Date:

Date Packet Submitted to DXC/MCO: Date Provider PA Request Packet Received: Not Received: Date of Referral to PAL (Untimely PA Packet Submission): Date of Decision: Date PA Notice Received: Date of Referral to PAL (Untimely PA Notice): Amount of Service Approved:

PA Begin Date: PA End Date: Service Start Date: PA Issued within 60 Days of Request: NA Explanation, if not issued: Date Renewal Sent and new tracking started: Date Denial of Service Notice Received:

Approval/Denial Status: Reason for Denial: Date MCO Appeal Rights Explained: Offered to help with MCO Appeal Date: Is Client Appealing: Request Assistance with MCO Appeal: Date Appeal Sent to MCO:

20 Day MCO Appeal Follow Up: Date of MCO Appeal Decision: MCO Appeal Outcome: MCO Appeal Notes: Date Appeal Rights Explained: Date Appeal Brochure Provided: Offered to help with appeal Date: Is Client Appealing:

Request Assistance with Appeal: Date Appeal Sent to LDH: 20 Day Appeal Follow Up: 90 Day Appeal Follow Up: Date of Appeal Decision: Appeal Outcome:

Notes:

Save
Cancel



LSCIS Service Log

- The EPSDT Service Log should be used for documenting activities related to EPSDT services.
- A separate service log should be used when possible to document activity related to a specific requested prior authorized service as identified on the EPSDT Prior Authorization Tracking Log.
- All contacts with the Participant, Provider, Medicaid Managed Care Case Manager, PAL, SRI, and LDH Program Staff Line must be documented including monthly and as needed contact with the participant/family to check status of implementation of services.
- Document receipt of the approval, denial or reduction of services.

LSCIS Service Log

LSCIS Service Log Form V 3.45 Site: 0299030 Thursday, March 17, 2016 [Log Out: Sally](#)

[My Home](#) [LSCIS Start Page](#)

[Find Client](#) [Add Client](#) [Find Services](#) [Add Services](#) [Reviewable CPOCs](#) [Reports](#) [Electronic PA](#)

[Denied CPOCs](#)

Ticket No: Case No: S. C. Sally Coordinator

1. Date: 03/17/2016 5. Activity: P/P Contact

2. Begin Time: : End Time: :

3. Place: 7. Service Participants:

4. Type of Contact:

Entered: Modified: Reviewed:

8. Begin Mileage: End Mileage:

9. Minutes spent documenting log: 0

Service Need:

Notes:



Prior Authorization Liaison



Medicaid Prior Authorization Packet *(Appendix R)*



Prior Authorization Liaison



Established to facilitate the PA approval process for Medicaid recipients under age 21 who are part of the Developmental Disabilities Request for Services Registry.



Prior Authorization Liaison



- The Chisholm v. Hood 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
 - 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, participant, 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, participant and support coordinator advising them of the specific documentation needed.
- The needed documentation must be returned to the PAL within 30 days of the notice date.



Prior Authorization Liaison



- Support Coordinator Role
 - Communicate promptly with the PAL to facilitate requests for information.



Prior Authorization Liaison



- Support Coordinator Role (continued)
 - Track status of requests:
 - Advise PAL of providers not actively developing requests.
 - Inform participants of right to choose another provider.
 - Assist participants in locating another provider.
 - Communicate with the family and provider and provide assistance in assembling documentary support on prior authorization requests.



Prior Authorization Liaison



- Support Coordinator Role (continued)
 - Follow up so that a PA decision is received, instead of having the service denied due to a lack of information.
 - If a “Notice of Insufficient Documentation” is received, assist the participant in obtaining documentation. If you are not sure enough additional information is available, help the recipient schedule a doctor’s appointment and return the second page of the Notice filled in with the date of the appointment to the PAL.
 - If a PAL referral is done, notify them of any scheduled doctor appointments.



Prior Authorization Liaison



- **Contacts**

- **DXC PAL**

Monica Anderson

225-216-3224

Fax: 225-216-6478

DXC Healthcare

Prior Authorization Liaison

P. O. Box 14919

Baton Rouge, LA 70898-4919

- **Medicaid 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 DXC PAL to return calls to her.

Prior Authorization Liaison MCOs

- **Aetna**
DeAnraanee Emery
Phone: 959-299-6412
Fax: 844-227-9205

Raven Taylor
Phone: 959-299-9483
Fax: 844-227-9205
- **Healthy Blue**
Danielle Huston - Medical Management Specialist II
Danielle.hutson@anthem.com
Phone: 877-440-4065 (ext. 106-123-9205)
Fax: 888-533-2750

Shannon Jumonville - Medical Management Specialist II
LA1-Chisholm@healthybluela.com
Phone: 877-440-4065 (Ext 106-122-4801)
Fax: 888-533-7250
- **AmeriHealth Caritas Louisiana**
Kathryn Cox— Prior Authorization Nurse
kcox@amerihealthcaritasla.com
Phone: 843-414-3149
Fax: 866-397-4522

Carrie Reed - Utilization Management Manager
cfreed@amerihealthcaritasla.com
Phone: 843-746-7558
- **Louisiana Healthcare Connections**
Carolyn Mather, RN
carolyn.mather@louisianahealthconnect.com
Phone: 225-201-8420
Fax: 877-668-2079

Albert Hart, RN
Albert.h.hart@louisianahealthconnect.com
Phone: 225-663-5768
Fax: 1-877-668-2079
- **UnitedHealthcare**
Sylvia Rugg - RN (Primary PAL)
sylvia_rugg@uhc.com
Phone: 651-414-8821
Fax: 855-557-7887

Moniqueko Percival (Back-Up PAL)
Moniqueko.l.percival@uhc.com
Phone: 800-377-5105, Option 4
Fax: 855-557-7887



Prior Authorization Liaison



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



Prior Authorization Liaison



To summarize the PAL and Support Coordinator's roles:

- If additional information is needed to process the request, the PAL will contact the provider, participant, 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.



Coordination of Services

- **Follow-up shall be made with the participant as needed and at *least* monthly to ensure that all services identified on the CPOC have been implemented and he/she is receiving services in the amount approved and at the times requested.** (If the participant is not satisfied, the support coordinator shall follow-up with the provider. If it cannot be resolved, the support coordinator will forward a report to the PAL using the Referral to the PAL Form – BHSF-PF-03-015, *Appendix S*.)
- **You must report to BHSF ALL services where a decision was not made within 60 days from the completion of the CPOC or from the FOC date. When a new provider is chosen, the 60 days do not start over and these instances shall be included in the reporting.**



Coordination of Services

- If the approved services are different than those designated on the CPOC Typical Weekly Schedule, the schedule must be revised to reflect the actual approved services/schedule using the legally accepted correction procedure. The schedule change does not have to be sent to SRI at this time.
- You only need to contact previously approved providers if the participant wants a scheduling change.



Coordination of Services – Renewals of Prior Authorization

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.

- The Support Coordinator must send a reminder letter (Referral to Provider form – BHSF-PF-03-016, *Appendix Q*) to the provider no less than 45 or more than 60 calendar days prior to the expiration of the prior authorization.*

*For participants with a MCO, 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 days prior to the expiration of the prior authorization.

Coordination of Services - Appeals/Reduction in Service Requests

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

*Refer to *Medicaid Managed Care Appendix F* for information on internal Medicaid Managed Care Program appeals. Refer to the Appeals Brochure (*Appendix L*) – for information on appealing to the DAL after they have exhausted the Medicaid Managed Care Program appeal.

Coordination of Services -

Appeals/Reduction in service requests

- The support coordinator must ask the participant/family if they need/want assistance with filing the appeal.
- The support coordinator must assist with an appeal if assistance is wanted by the participant. Review the Appeals section of the EPSDT SC Training Handbook.
- Regardless of whether or not the support coordinator is assisting with the appeal, they must follow-up with the participant within **20** calendar days of the appeal request to see if they have received a response, and/or need additional assistance.

Coordination of Services -

Appeals/Reduction in service requests

- The support coordinator should follow-up again with the participant at least 90 days after the appeal was sent to check on the final decision regarding the appeal.
- Document all information on the electronic EPSDT Prior Authorization Tracking Log and EPSDT Service Log (LSCIS).

*For participants with a MCO refer to *Medicaid Managed Care Appendix F* for information on internal Appeals which must be exhausted before appealing to the DAL.



Follow-up Requirements

- After the CPOC meeting there must be contact at least monthly and as needed to:
 - Assure implementation of requested services.
 - Determine 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.
 - Offer to assist with an appeal.



Follow-up Requirements

- There must be a face-to-face contact at least quarterly to identify:
 - Service needs and status through review of the CPOC.
 - Completion of the EPSDT Quarterly Review/ Checklist and Progress Summary (LSCIS)

Note: The original signature page must be kept in the case record. Refer to pages 79-80 for instructions on completing the Quarterly Review.



Follow-up Requirements

- Additional services requested.
 - Scheduling issues (update the Typical Weekly Schedule).
-
- Note: The face-to-face quarterly visit does not have to be completed in the participant's home.

LSCIS CPOC Quarterly Review

2. Medical/Social/Family History
 3. CPOC Service Needs and Supports
 4. CPOC Participants
 5. CPOC Approval Information
 CPOC Quarterly Review
 Approval Denial Notes History

| Service Needs | Requesting Services | Receiving Services | Expiration Date of PA | Referred to PAL | Appeal Process | Progress Status of Service/ Receiving amount PA |
|---|-------------------------------------|-------------------------------------|-----------------------|-----------------|----------------|---|
| Dental Services (1) Routine Check up | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | NA | NA NA | NA | |
| Diapers (1) Incontinence Supplies | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | |
| OT (1) Motor Skills | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | NA | NA NA | NA | |
| Other (4) Allergiest | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | NA | NA NA | NA | |
| Other (6) Gastro | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | NA | NA NA | NA | |
| Other (1) Development Specialist | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | NA | NA NA | NA | |
| Other (3) FSA: Samsung tablet | <input type="checkbox"/> | <input type="checkbox"/> | NA | NA NA | NA | |
| Other (5) ENT | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | NA | NA NA | NA | |
| Other (7) APE | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | NA | NA NA | NA | |
| Speech Therapy (1) Communication | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | NA | NA NA | NA | |

Health Changes (include Nutritional Changes)
 Safety Issues
 Changes in Living Situations
 Medicaid Services Chart
 Rights and Responsibilities
 Grievance Policy
 Abuse Policy
 Health Standards Provider compliant (1-800-660-0488)
 Medicaid Managed Care Program Assistance/
 Compliance Line (1-888-342-6207)

Are you requesting any medically necessary therapies now or want to receive therapies on the IEP during the school's summer break?

| | | |
|---|--------------------------------------|----------|
| Participant Questions | Participant Compliant Form Completed | Comments |
| Are you receiving the services that you requested? | <input type="checkbox"/> | |
| Are the Services at the day/time needed? | <input type="checkbox"/> | |
| Are you pleased with the services that you are receiving? | <input type="checkbox"/> | |
| Are there Additional services that you need? | <input type="checkbox"/> | |

Notes(Include narrative description of Above CMIS codes, additional explanations as needed and summary status and progress for quarter)

Support Coordinator: Date:

| Names of Attendees | Relation/Title/Agency | Date |
|--------------------|-----------------------|------|
| | | /// |
| | | /// |
| | | /// |
| | | /// |



Follow-up Requirements - Forms

- The CPOC including the Typical Weekly Schedule (Appendix O) must be revised to reflect any changes in status or information and for the addition of new services or changes in existing services.
- Participant Complaint Form (BHSF-RF-03-010, *Appendix M*) shall be used as needed by the participant to make a complaint against a direct service provider/worker or a support coordinator.
- The Medicaid Managed Care Program Assistance Line (1-888-342-6207) shall be used as needed by the Participant to make a complaint against a MCO. Complaints against MCOs can also be e-mailed to healthy@la.gov.
- Service delivery issues use the Referral to PAL (BHSF-PF-03-015, *Appendix S*).



Follow-up Requirements – EPSDT Quarterly Report

- The EPSDT Quarterly Report is due to BHSF/SRI by the 5th day of the month following the end of the quarter using the Quarterly Report Checklist (*Appendix W-1*) and must include:
 - A print out of the Quarterly Report From LSCIS
 - 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 participants without a Choice of Provider
 - Documentation of EPSDT Training for any new hires
- **Quarterly Report Due Dates:**
 - **April 5**
 - **July 5**
 - **October 5**
 - **January 5**



Follow-up Requirements - EPSDT Quarterly Report

- The EPSDT Quarterly Report will be completed using information entered into LSCIS by the Support Coordination Agency. All required information must be entered into LSCIS at the end of each quarter so that the report can be generated.



Follow-up Requirements - EPSDT Quarterly Report

- When significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment, the CPOC should be updated in LSCIS. Goals and objectives should be added and/or revised according to the most recent information available. The Typical Weekly Schedule should be revised to reflect the changes.
- The **Quarterly Report of CPOC Revisions** (*Appendix W-2*) - a list of participants that have a revised/updated CPOC must be submitted to SRI with the Quarterly Report for each quarter that changes are made to the CPOC along with a copy of the **Service Needs Changes Report** from LSCIS.



Follow-up Requirements - EPSDT Quarterly Report

- The Quarterly Report will include the names of the participants and the services for the following:
 - Participants whose request for services did not result in a PA being issued within 60 days.
 - Participants with gaps in the authorization period.
 - Participants who submitted requests for appeals within the quarter.
- As part of the identification, the SC Agency must review all documentation (CPOC, Prior Authorization Tracking Log, Service Logs, etc.) prior to end of each Quarter.
- Either the number of trackings without a choice of provider must be zero or documentation and explanation must be attached for each participant and service without a choice of provider.



Follow-up Requirements - EPSDT Quarterly Report

- The **Record Review for the Quarterly Report** (Appendix W-3) is to be completed for each participant/service listed on the LSCIS Quarterly Report as not having a PA issued within 60 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.
- The EPSDT Specialist, if they are not the Support Coordinator involved, is to complete the form. If the Support Coordinator involved in these cases is the EPSDT Specialist, the Onsite Program Manager or Supervisor are to complete the form.



Follow-up Requirements - EPSDT Quarterly Report

- BHSF/SRI and the LDH attorney will review the information to assure that the participants are receiving the services they need and the assistance they need to access the services. BHSF/SRI will review the PA Tracking and Services Logs and may request additional documentation and information from the support coordination agencies.



Requirements for Support Coordination Agencies

- All Support Coordinators must receive EPSDT training.
- New support coordinators and trainees must receive EPSDT training
 - during orientation (must be included as part of the required 16 hours of orientation training), and
 - prior to being assigned an EPSDT caseload.
- All support coordinators and trainees must complete the EPSDT training each year. The agency's Designated Trainer and Supervisors will be responsible for training the staff.



Requirements for Support Coordination Agencies

- Newly designated EPSDT Trainers and Supervisors must receive the EPSDT training:
 - during orientation, and
 - prior to beginning supervision of EPSDT support coordinators.
- All designated Trainers and Supervisors must complete EPSDT training each year. 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 Program Manager.
- Documentation of annual training must be submitted one time each year.
- Documentation of training for new staff must be submitted by the last day of each quarter, if applicable for that quarter.



Requirements for Support Coordination Agencies

- LSCIS Reports

The On-Site 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.**



Reminders

- The purpose of Support Coordination is to coordinate all services and to ensure the participant receives the services he/she needs.
- If at any time a provider is not actively working on behalf of the participant, contact the PAL.
- Contact SRI if you have questions or your BHSF State Office regarding policy.



EPSDT – Targeted Population

Support Coordination Training

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 basic behavioral health
- Covers 950,000 Louisianans
- Five managed care organizations (MCOs) working statewide:
 - Aetna
 - Amerihealth Caritas Louisiana
 - Healthy Blue
 - Louisiana Healthcare Connections
 - United Healthcare Community Plan



Chisholm Class Members in the Medicaid Managed Care Program

- Voluntary Opt-In population (Physical Health)
 - May enroll in a MCO for their physical health 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.
 - Enrollees 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.
 - Enrollees have until the 2nd to last business day of the month to enroll/disenroll with a MCO for the effective date to be the first of following month.



Chisholm Class Members in the Medicaid Managed Care Program

- Behavioral Health
 - Effective 12/1/2015 enrollment of all Medicaid members in a MCO for their behavioral health services and for transportation services became mandatory.
 - Chisholm Class Members cannot opt out of the MCO for their behavioral health services.
- NEMT
 - All non-emergency medical transportation will be provided by the MCOs.



Examples

Enrollment:

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

4.25.19

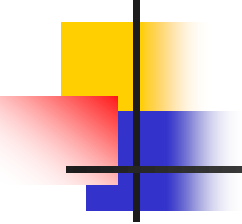
Cut Off:

- CCM calls the Medicaid Managed Care Program on April 30th to enroll in the MCO, the effective date of enrollment will be June 1st.
- CCM calls the Medicaid Managed Care Program on April 29th to enroll, their effective date will be May 1st.



Switching Plans

- Chisholm Class Members (CCM) can call the Medicaid Managed Care Program at 1-855-229-6848, TTY: 1-855-526-3346 or go online at www.healthy.louisiana.gov to enroll or dis-enroll.
- CCMs have a 90 day choice period during which they can change MCOs for any reason.
- After 90 days, CCMs will be locked in to the MCO for 12 months from the effective date of enrollment or until the next annual open enrollment, unless they opt out of the Medicaid Managed Care Program or show cause for disenrollment from the MCO.



Medicaid Managed Care Program Excluded Services



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



Excluded Services

- MCO enrollees may obtain the excluded services under the Louisiana State Plan; however, DXC 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



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 (cont.)

- Examples of Value Added Benefits include:
 - Gift cards that can be used to purchase health related items.
 - Free Boy or Girl Scout annual membership
 - Free Cell Phones
 - Weight management programs



Medicaid Managed Care Program Support Coordination Role



Selecting a Plan

- Support Coordinators should assist CCMs with selecting a MCO by providing information on all 5 plans.
- Support Coordinators should ensure that the CCMs providers are in network and that the medications that they are currently prescribed are covered by the MCO's formulary. (See *HL Appendix B* for links to plan websites.)
- Support Coordinators can use the MCOs Comparison Chart (*Medicaid Managed Care Appendix G*) to assist the CCM with their selection.
- CCMs can call the Medicaid Managed Care Program at 1-855-229-6848 to enroll or go online at www.healthy.louisiana.gov.

What the CCM should 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.
- Support Coordinators should familiarize themselves with the Member Handbooks for each MCO.



Member Handbooks Online

- Aetna:
<http://www.aetnabetterhealth.com/louisiana/assets/pdf/members/MemberHandbook-Eng-LA.pdf>
- AmeriHealth Caritas Louisiana:
<http://www.amerihealthcaritasla.com/pdf/member/handbook/english.pdf>
- Healthy Blue:
<https://www.myhealthybluela.com/la/benefits/member-resources.html>
- Louisiana Healthcare Connections:
<https://www.louisianahealthconnect.com/content/dam/centene/louisiana-health-connect/pdfs/medicaid-member/Member-Handbook-Integrated.pdf>
- United Healthcare Community Plan:
<https://www.uhccommunityplan.com/assets/plandocuments/handbook/en/LA-Integrated-Health-Services-Handbook-EN.pdf>



Accessing Services

- Support Coordinators should utilize the *Medicaid Managed Care Services 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, the Medicaid Managed Care Program Prior Authorization Liaison and the Medicaid PAL via phone, email, fax or referral form.



Locating Providers

- Support Coordinators should assist the CCM 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 between Behavioral Health and 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-EPSTD" listed under PCP/Specialties on the list of providers.
 - Call the Member Services Line at each MCO to locate a provider in their network.
 - Access MCOs' websites to identify contracted providers.



Member Services Numbers

- Aetna Better Health
 - 1-855-242-0802
- AmeriHealth Caritas Louisiana
 - 1-888-756-0004
- Healthy Blue
 - 1-844-521-6941
- Louisiana Healthcare Connections
 - 1-866-595-8133
- United Healthcare Community Plan
 - 1-866-675-1607

* Operate from 7:00am-7:00pm, Monday thru Friday.

What if a provider is not available?



- If you cannot find a provider from the Medicaid Managed Care Program's website, or the provider directory, which is willing to submit a prior authorization request, 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 with locating a provider.
- If the MCO is unable to locate a willing provider within 10 days, the Support Coordinator should submit a referral to the LDH Medicaid PAL.



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.



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 an enrollee 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.



Communication

- Support Coordinators should send referral to Medicaid Managed Care Case Management once a CCM selects a provider.
- 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.
- Support Coordinators should send referrals to Medicaid Managed Care Case Management to inform them of expiring service authorizations.

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



Communication cont'd...

- Support Coordinators should send a referral to Medicaid Managed Care Case Management (*Medicaid Managed Care Appendix Q*) if:
 - a referral for a service is needed.
 - a provider cannot be located to submit a request for prior authorization for services.
 - a CCM selects a new provider.
 - a CCM wants to choose a new provider.
 - a CCM is requesting a change in schedule.
 - a prior authorization is about to expire or expired.
 - a provider is not providing the amount of services as per the CPOC and as prior authorized.
 - The participant has been advised of their right to choose another provider and the SC is beginning the process again.
 - The participant has been advised of their right to choose another provider but has decided to stay with the same provider and wait until the PA packet is submitted.



Communication cont'd

- Support Coordinators should send referrals to the Medicaid Prior Authorization Liaison (*Medicaid Managed Care Appendix S, S-1, S-2*) 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 within 10 days of the Referral to Medicaid Managed Care Case Management.
 - A provider is not providing the amount of services as per the CPOC or as prior authorized, or a provider is not providing services at the times the participant requested and the MCO was unable to resolve the issue within 10 days of the Referral to Medicaid Managed Care Case Management.
 - The SC has been unable to find a provider that is willing to submit a request for a PA and the MCO was unable to resolve the issue within 10 days of the Referral to Medicaid Managed Care Case Management. (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.)



Communication cont'd...

- Support Coordinators should send referrals to the Medicaid Prior Authorization Liaison (*Medicaid Managed Care Appendix S, S-1, S-2*) if:
 - The participant has been advised of their right to choose another provider and the SC is beginning the process again.
 - The participant has been advised of their right to choose another provider but has decided to stay with the same provider and wait until the PA packet is submitted.
 - The SC has not received a notice of approval for the renewal approval and the previous PA expired.

*See Medicaid Managed Care Appendix T-2, and T-3 for timeline information.



Questions and Answers

- 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.

Medicaid Managed Care

Appendices



- MCO Contacts for Support Coordinators (Medicaid Managed Care A)
- Medicaid Managed Care Program Services - Links and Phone Numbers (Medicaid Managed Care B)
- Change in PCS provider during PA period (Medicaid Managed Care C)
- Medicaid Managed Care Program PCS and EHH PA Time frames (Medicaid Managed Care D)
- MCO PAL Flowchart (Medicaid Managed Care E)
- Medicaid Managed Care Program Appeals Timelines and Documentation (Medicaid Managed Care F)
- MCOs Comparison Chart (Medicaid Managed Care G)
- Referral to Medicaid Managed Care Case Management (Medicaid Managed Care Q)
- Medicaid Managed Care Program Referral to PAL (Medicaid Managed Care S)
- Medicaid Managed Care Program EPSDT Timelines & Documentation - Participant (Medicaid Managed Care T-1)
- Medicaid Managed Care Program EPSDT Timelines & Documentation – Provider (Medicaid Managed Care T-2)
- Medicaid Managed Care Program EPSDT Timelines and Documentation – PAL (Medicaid Managed Care T-3)