LOUISIANA DEPARTMENT OF HEALTH

Application Center Monthly Contact

Presented by:
Valerie McManus, AC Program Manager
November 20, 2024

Agenda Items

LOUISIANA DEPARTMENT OF HEALTH

- Open Enrollment
- Situational Forms
- Document Submission
- Reminders

Open Enrollment

LOUISIANA DEPARTMENT OF HEALTH

- Medicaid members have the opportunity to change their health or dental plans during Open Enrollment from October 15, 2024, to 6 p.m. on December 2, 2024, with changes becoming effective on January 1, 2025. Staying on their current plan requires no action.

- Changes can be made via mail, fax, the Healthy Louisiana app, myplan.healthy.la.gov, or by calling 1-855-229-6848 from 8am to 5pm. This is the sole time for plan changes without special justification, aside from the initial enrollment period.

Open Enrollment (cont.)

LOUISIANA DEPARTMENT OF HEALTH

- There are six health plans and two dental plans to select from. All offer basic benefits and management programs, with some providing additional services based on age and need.

Health

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

Dental

DentaQuest	MCNA Dental

Open Enrollment (cont.)

LOUISIANA DEPARTMENT OF HEALTH

- Members can select the “Choose” option on myplan.healthy.la.gov and click to “Find a medical or dental provider,” to view the providers that accept their plan.
- The Open Enrollment flyer has been added to the AC Resource Library’s homepage. Please ensure that it is posted in highly visible areas of your facility.

Open Enrollment (cont.)

LOUISIANA DEPARTMENT OF HEALTH

- The new English and Spanish Health Plan and Dental Plan Comparison Charts are available under the AC Forms and Publications section of the AC Resource Library.

Health Plan Contact Information

Aetna Better Health **1-855-242-0802** TTY: 711 Available 24 hours a day, 7 days a week.

AmeriHealth Caritas **1-888-756-0004** TTY: 1-866-428-7588 Available 24 hours a day, 7 days a week.

Healthy Blue **1-844-521-6941** TTY: 711 Available Monday – Friday, 7:00 a.m. - 7:00 p.m.

Humana Healthy Horizons **1-800-448-3810** TTY: 711 Available Monday – Friday, 7:00 a.m. – 7:00 p.m.

Louisiana Healthcare Connections **1-866-595-8133** TTY: 711 Available Monday – Friday, 7:00 a.m. – 7:00 p.m.

UnitedHealthcare Community **1-866-675-1607** TTY: 711 Available Monday – Friday, 7:00 a.m. – 7:00 p.m.

Dental Plan Contact Information

DentaQuest **1-800-685-0143** TTY: 1-800-466-7566 Live agents are available from 7:00 a.m. - 7:00 p.m. with the IVR active 24 hours a day (no matter if it is a holiday).

MCNA Dental **1-855-702-6262** TTY : 1-800-846-5277 Available Monday - Friday, 7:00 a.m. - 7:00 p.m.

Situational Forms

LOUISIANA DEPARTMENT OF HEALTH

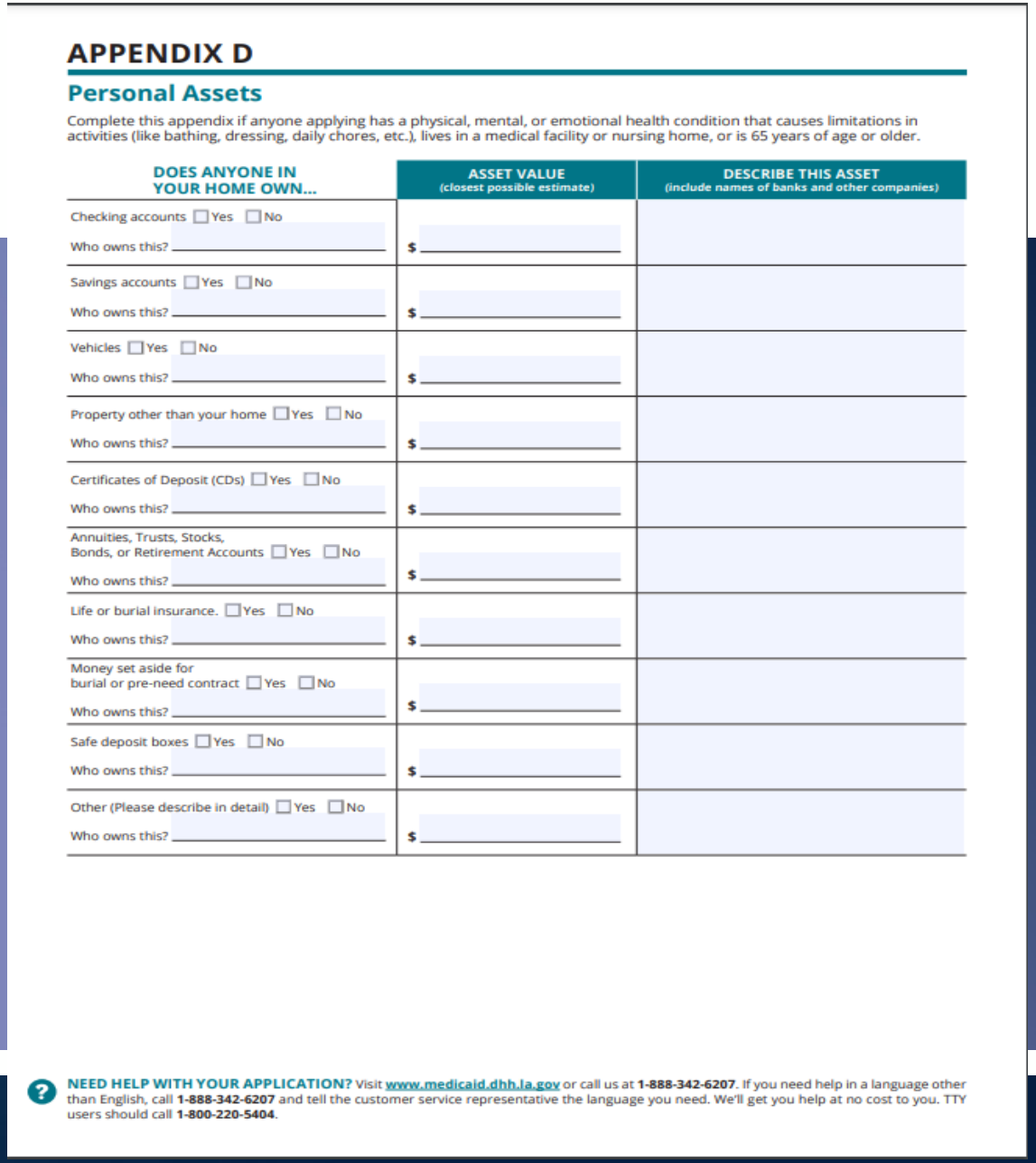
- If an applicant alleges a physical, emotional or mental health condition that causes limitations, please ensure that the appropriate situational forms accompany the application.
    - Appendix D
    - BHSF Form MS or MS/C
    - HIPAA 202L or 402P
- These forms are only needed if the applicant alleges a disability.

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

Appendix D

- This form is used to determine resource eligibility.
- It should be completed for anyone that alleges limitations in activities like bathing, dressing, daily chores, etc., lives in a medical facility or nursing home, or is 65 years of age or older.



APPENDIX D

Personal Assets

Complete this appendix if anyone applying has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), lives in a medical facility or nursing home, or is 65 years of age or older.

DOES ANYONE IN YOUR HOME OWN...	ASSET VALUE (closest possible estimate)	DESCRIBE THIS ASSET (include names of banks and other companies)
Checking accounts ☐ Yes ☐ No Who owns this? _____	$ _____	
Savings accounts ☐ Yes ☐ No Who owns this? _____	$ _____	
Vehicles ☐ Yes ☐ No Who owns this? _____	$ _____	
Property other than your home ☐ Yes ☐ No Who owns this? _____	$ _____	
Certificates of Deposit (CDs) ☐ Yes ☐ No Who owns this? _____	$ _____	
Annuities, Trusts, Stocks, Bonds, or Retirement Accounts ☐ Yes ☐ No Who owns this? _____	$ _____	
Life or burial insurance. ☐ Yes ☐ No Who owns this? _____	$ _____	
Money set aside for burial or pre-need contract ☐ Yes ☐ No Who owns this? _____	$ _____	
Safe deposit boxes ☐ Yes ☐ No Who owns this? _____	$ _____	
Other (Please describe in detail) ☐ Yes ☐ No Who owns this? _____	$ _____	

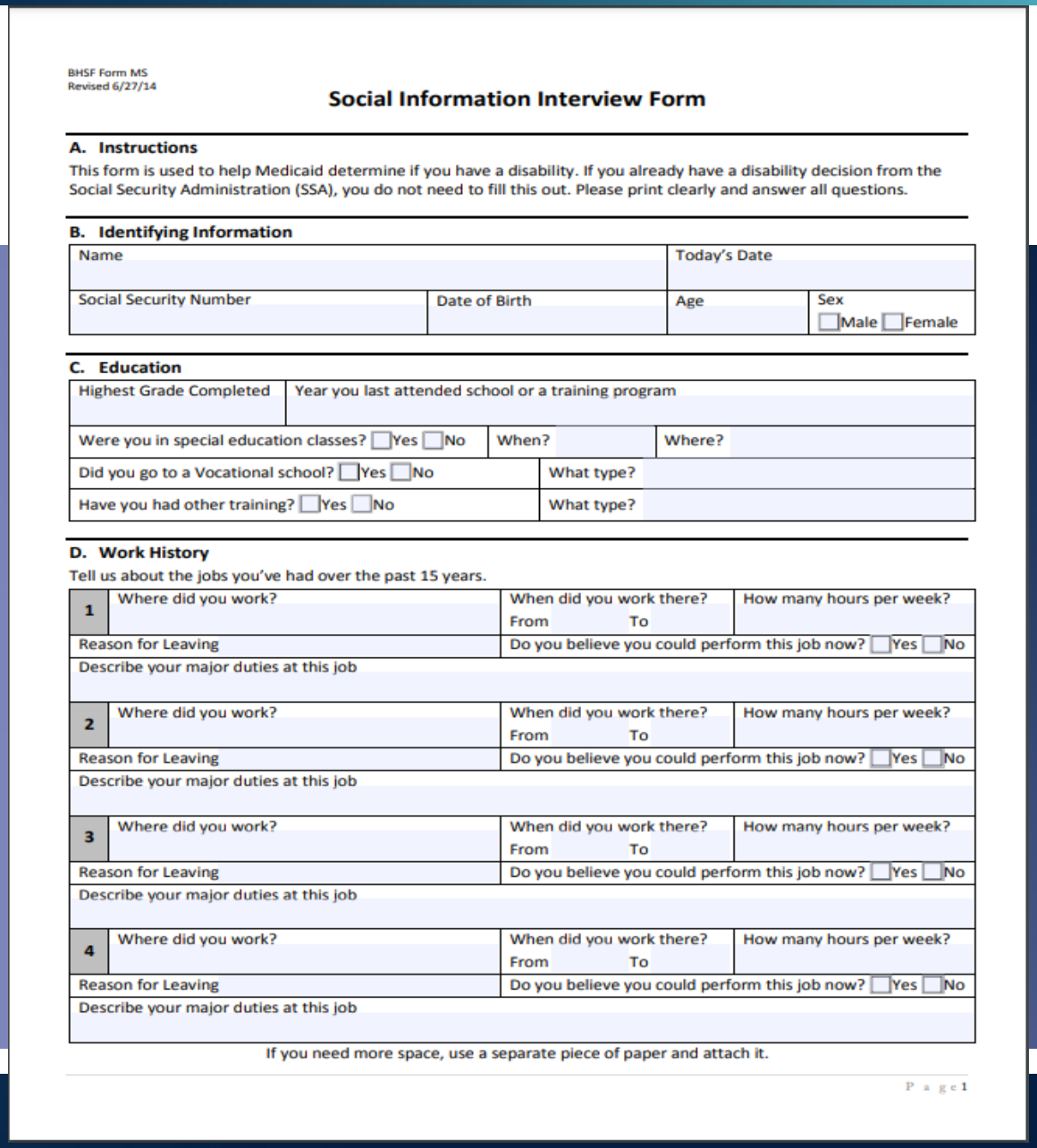
NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.dhh.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

BHSF Form MS (Social Information Interview Form)- Adult

- This form is used to help Medicaid determine if a person has a disability.
- If an applicant is age 65 or older or has already received a disability decision from the Social Security Administration (SSA), this form does not need to be filled out.



BHSF Form MS
Revised 6/27/14

Social Information Interview Form

A. Instructions

This form is used to help Medicaid determine if you have a disability. If you already have a disability decision from the Social Security Administration (SSA), you do not need to fill this out. Please print clearly and answer all questions.

B. Identifying Information

Name		Today's Date	
Social Security Number	Date of Birth	Age	Sex ☐Male ☐Female

C. Education

Highest Grade Completed	Year you last attended school or a training program		
Were you in special education classes? ☐Yes ☐No	When?	Where?	
Did you go to a Vocational school? ☐Yes ☐No	What type?		
Have you had other training? ☐Yes ☐No	What type?		

D. Work History

Tell us about the jobs you've had over the past 15 years.

1	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐Yes ☐No	
Describe your major duties at this job			
2	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐Yes ☐No	
Describe your major duties at this job			
3	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐Yes ☐No	
Describe your major duties at this job			
4	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐Yes ☐No	
Describe your major duties at this job			

If you need more space, use a separate piece of paper and attach it.

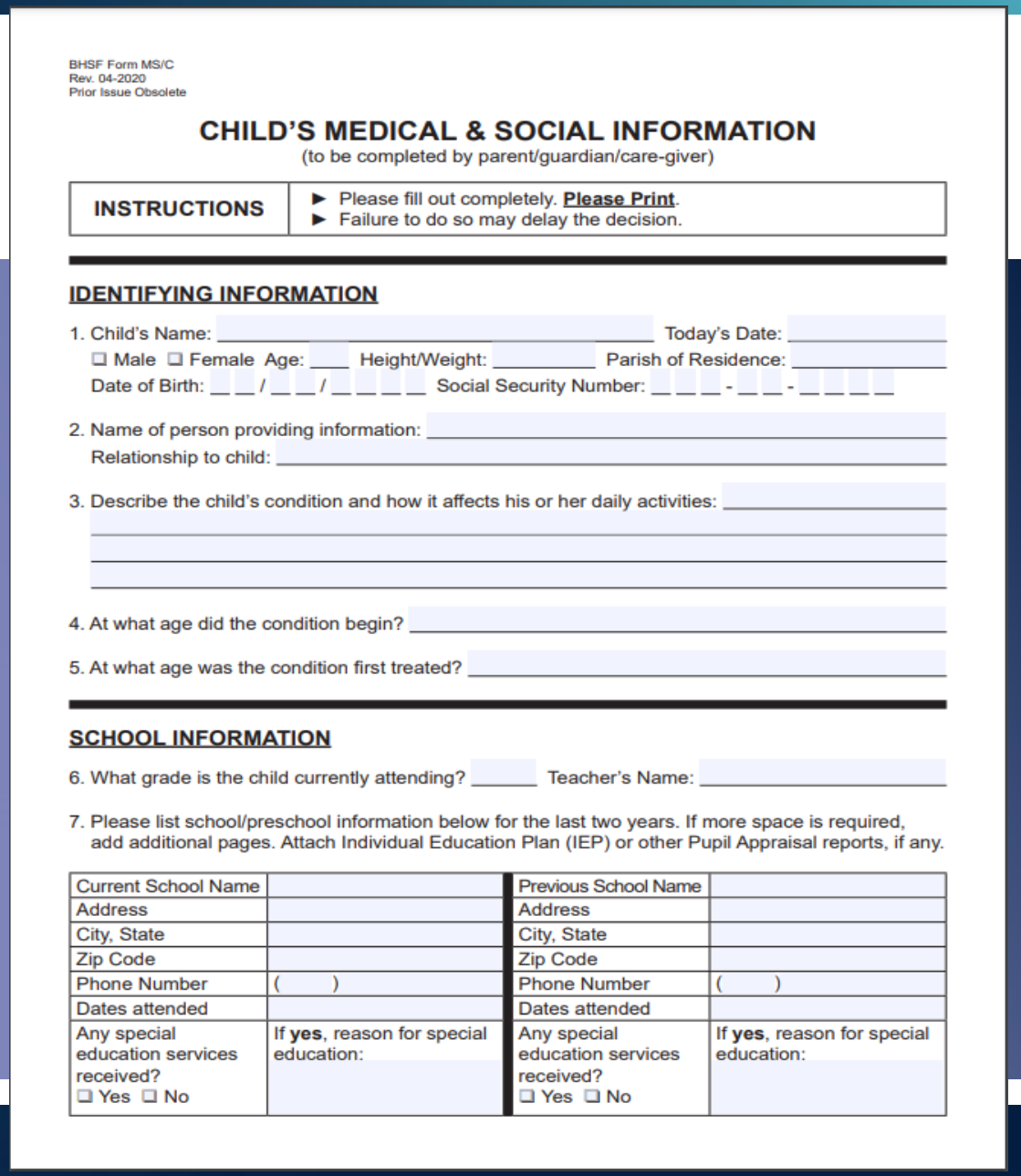
Page 1

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

BHSF Form MS/C (Social Information Interview Form)- Child

- This form should be completed by the parent/guardian/care-giver that alleges disability on behalf of their child.



BHSF Form MS/C
Rev. 04-2020
Prior Issue Obsolete

CHILD'S MEDICAL & SOCIAL INFORMATION
(to be completed by parent/guardian/care-giver)

INSTRUCTIONS	► Please fill out completely. **Please Print**. ► Failure to do so may delay the decision.

IDENTIFYING INFORMATION

1. Child's Name: _____ Today's Date: _____
   ❑ Male ❑ Female Age: ___ Height/Weight: _____ Parish of Residence: _____
   Date of Birth: __ __ / __ __ / __ __ __ __ Social Security Number: __ __ __ - __ __ - __ __ __ __
2. Name of person providing information: _____
   Relationship to child: _____
3. Describe the child's condition and how it affects his or her daily activities: _____
4. At what age did the condition begin? _____
5. At what age was the condition first treated? _____

SCHOOL INFORMATION

6. What grade is the child currently attending? _____ Teacher's Name: _____
7. Please list school/preschool information below for the last two years. If more space is required, add additional pages. Attach Individual Education Plan (IEP) or other Pupil Appraisal reports, if any.

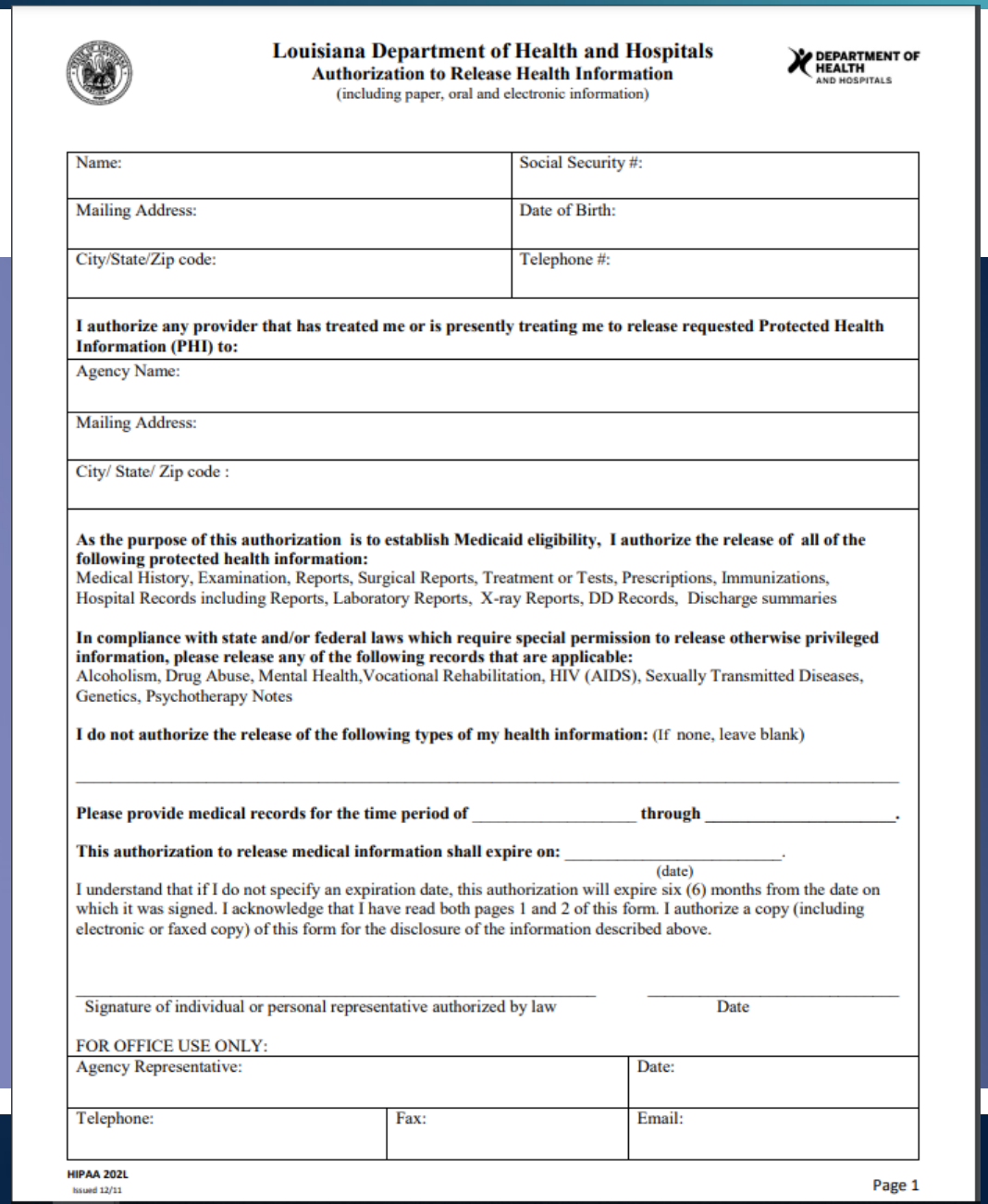
Current School Name		Previous School Name	
Address		Address	
City, State		City, State	
Zip Code		Zip Code	
Phone Number	( )	Phone Number	( )
Dates attended		Dates attended	
Any special education services received? ❑ Yes ❑ No	If **yes**, reason for special education:	Any special education services received? ❑ Yes ❑ No	If **yes**, reason for special education:

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

HIPAA 202L

- This form is used to request medical records on the behalf of an applicant.
- A separate form should be completed for each provider that the applicant names.



Louisiana Department of Health and Hospitals
Authorization to Release Health Information
(including paper, oral and electronic information)

DEPARTMENT OF HEALTH AND HOSPITALS

Name:	Social Security #:
Mailing Address:	Date of Birth:
City/State/Zip code:	Telephone #:

I authorize any provider that has treated me or is presently treating me to release requested Protected Health Information (PHI) to:

Agency Name:

Mailing Address:

City/ State/ Zip code :

As the purpose of this authorization is to establish Medicaid eligibility, I authorize the release of all of the following protected health information:
Medical History, Examination, Reports, Surgical Reports, Treatment or Tests, Prescriptions, Immunizations, Hospital Records including Reports, Laboratory Reports, X-ray Reports, DD Records, Discharge summaries

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release any of the following records that are applicable:
Alcoholism, Drug Abuse, Mental Health,Vocational Rehabilitation, HIV (AIDS), Sexually Transmitted Diseases, Genetics, Psychotherapy Notes

I do not authorize the release of the following types of my health information: (If none, leave blank)

_____

Please provide medical records for the time period of _____ **through** _____.

This authorization to release medical information shall expire on: _____.
(date)

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

_____ _____
Signature of individual or personal representative authorized by law Date

FOR OFFICE USE ONLY:

Agency Representative:		Date:
Telephone:	Fax:	Email:

HIPAA 202L
Issued 12/11

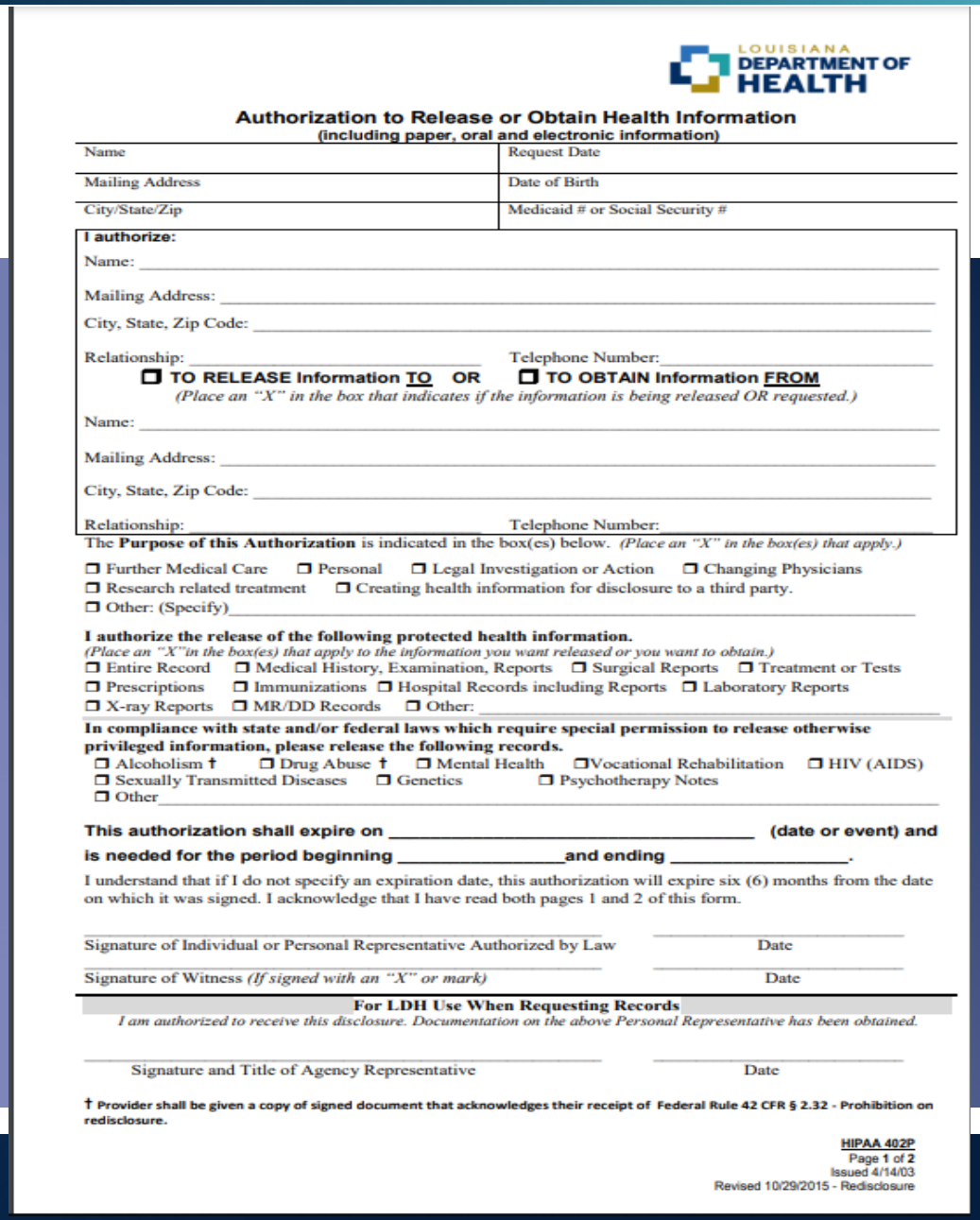
Page 1

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

HIPAA 402P

- This form is used to request medical records on the behalf of an applicant.
- A separate form should be completed for each provider that the applicant names.



LOUISIANA DEPARTMENT OF HEALTH

Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid # or Social Security #

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

❒ **TO RELEASE Information TO OR** ❒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action ❒ Changing Physicians
❒ Research related treatment ❒ Creating health information for disclosure to a third party.
❒ Other: (Specify) _____

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)
❒ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
❒ Alcoholism † ❒ Drug Abuse † ❒ Mental Health ❒ Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other _____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness *(If signed with an "X" or mark)* Date

For LDH Use When Requesting Records
I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

† **Provider shall be given a copy of signed document that acknowledges their receipt of Federal Rule 42 CFR § 2.32 - Prohibition on redisclosure.**

Document Submission

LOUISIANA DEPARTMENT OF HEALTH

- Medical bills are only needed if a person alleges a disability or has a minor child in the household.
- Please refrain from submitting verifications that do not apply to the applicant's situation.

Reminders

LOUISIANA DEPARTMENT OF HEALTH

- AC Resource Library – Check it DAILY
- Ensure you log into the PARTNER portal and not the Public or Provider portal.
- Adhere to Medicaid guidelines
- Trusted Users must conduct Face-to-Face interviews
- For issues with newborns, email NEU@la.gov
- EMS
  - Submit medical records immediately upon receiving the denial due to non-citizenship. They should be sent to the EMS Rightfax (225) 389-2748 (Local) or (877) 747-0996 (Toll-free).
  - For aged EMS claims, email the EMS Aged Claims Status Request form (on the AC Resource Library) to MEDT-EMS@la.gov.
- AC Meetings are conducted on your behalf. Attendance is required and participation is encouraged.

Reminders (cont.)

LOUISIANA DEPARTMENT OF HEALTH

Code 155 Denials

- Individuals with Emergency Services limitations on their benefits require a medical review by Medicaid's Medical Eligibility Determination Team (MEDT).
- Fax medical records for the EMS date of service to **(225) 389-2748 Local or (877) 747-0996 Toll-free**. Medicaid will not pay for non-emergent medical services rendered to EMS individuals.

Reminders (cont.)

LOUISIANA DEPARTMENT OF HEALTH

- The only records that should be faxed to the EMS fax numbers are the ones pertaining to EMS-related certifications that are still open due to COVID.
- The number is not for new applications.
- Verifications for new applications should still be faxed to the LaCHIP Rightfax number, 1-877-523-2987.

Reminders (cont.)

LOUISIANA DEPARTMENT OF HEALTH

Application Centers (AC)

- ApplicationCenter.Service@la.gov
- (225) 342 – 6312
- Valerie McManus

Medical Eligibility Determinations Team (MEDT)

- MEDT@la.gov
- Angel Wilson Jolivette

Newborn Eligibility Unit (NEU)

- NEU@la.gov
- Kiarah Dugas

Medicaid Outreach

- MedicaidOutreach@la.gov

Optional State Supplement (OSS)

- OSS@la.gov
- (225) 342 – 1646
- Paige Logan

Outstation

- Outstation@la.gov
- (225) 342 – 1646
- Paige Logan

Healthy Louisiana

1-855-229-6848

Louisiana Medicaid Customer Service

1-888-342-6207

Questions

THANK YOU

LOUISIANA
DEPARTMENT OF
HEALTH