# Quarterly Provider Meeting Updates

# June 26, 2025

The OCDD quarterly provider meeting was held on Thursday, June 26, 2025. The following topics were discussed. Kim Kennedy opened the meeting reminding providers that agenda items are requested in advance, and the discussions today will address the agenda items submitted.

## SETTINGS RULE COMPLIANCE

LDH received our final signoff from CMS. The Cap was closed out by CMS. Letter received 5/29/25 remediation and validation activities are complete. Louisiana is currently in compliance. CMS will continue to make site visits in states. Annually LDH has to provide updates to CMS regarding Settings Rule compliance for the state. LDH is continuing with on-site visits so information can be provided to CMS annually regarding compliance. Now it should be every day practice to support individuals with personal choice and community integration. Additional meetings regarding continued compliance will occur in the future.

We did it! Thanks for all of your hard work. You are appreciated.

## PATIENT LIABILITY INCOME (PLI)

PLI is a program also known as Waiver Spenddown. Only 10 people in the OCDD population are impacted. There is an income limit of three times the SSI monthly stipend. So individuals who make over about $2900 a month may have to pay for part of their waiver services each month. The beneficiary will be responsible for paying the provider for services delivered up to the PLI amount each month.

A letter from Medicaid was posted in LaSRS on June 16, 2025. Please review the letter carefully. The letter provides an example of a remit that has PLI removed from the provider's reimbursement. The PLI amount that is removed from the reimbursement is on the weekly remittance advice (RA). Individuals that have a PLI have received a letter from Medicaid stating the monthly liability amount. Providers need to talk with the beneficiary that has a PLI to set up a way for the individual to pay any PLI deducted from the provider's RA.

Providers will only collect the amount of the PLI that is deducted on their RA. Providers cannot collect more than the PLI amount on the RA. Providers are responsible for determining how the beneficiary will pay the provider for any PLI deducted from the provider's RA.

The following is provided based on questions answered during the meeting.

- The deduction column will become the PLI column. We do not anticipate a change to the 835 electronic file structure; however, if there are any issues, the providers should check with Gainwell to determine if the structure to the electronic 835 RA file affecting the import of the electronic file.

- PLI is not affected by a reduction of hours for a beneficiary. The PLI is a set amount and will be deducted from the services billed for the month by the provider including support coordination. If a beneficiary receives less services than the amount of the PLI, the beneficiary is only responsible for the cost of the services received. Any PLI amount not used is not carried over to the next month. The next month, the PLI will start over.
- Support Coordinators who receive a decision notice with a waiver spenddown should reach out to providers to let them know the individual has a PLI. If a provider is receiving a new beneficiary for services, they can ask the beneficiary or the support coordinator if the individual has a PLI. The Local Governing Entities also receive information if an individual has a PLI. The individual's most current Decision Notice will indicate if they have a waiver spenddown amount.
- If a beneficiary does not pay the PLI deducted from the provider's RA, then there is recourse for the providers in HCBS Providers Licensing Standards. Please review the "Involuntary Discharge" portion of the HCBS Providers Licensing Standards in the Louisiana Administrative Code, Section 48, Chapter 50.

PLI is a monthly amount, and can change based on their income. This goes into effect for dates of service beginning July 1, 2025.

**PROVIDER ATTACHMENTS**

Provider attachments are required and are considered a part of the plan of care. The attachments need to be developed so that the direct care staff know what supports are required for the individual. The supports identified on the attachments must align with the plan of care, including support needs, goals or outcomes for which the provider is responsible. The attachments must be updated annually. Providers should take the attachments to the annual planning meeting and update them based on the meeting. Then when the support coordinator sends the new plan of care to the provider, the updated attachments can be compared to the plan of care and submitted to the support coordinator within the required timelines. A plan of care cannot be approved without the required provider attachments.

If Support Coordination or the Local Governing Entity (LGE) request updated or corrected attachments, then providers are responsible for submitting the corrected documents within two (2) working days. Just as a reminder, the LGE's are the operating arm for OCDD and providers are expected to respond to the LGE when requests are made.

Christy provided additional information about Attachments F and G.

- If an individual has active behavioral health (BH) diagnosis:
    - If formal BSP exists from a BH clinician then submit BSP. Attachment G is not required.
    - If no formal BSP, but there are recommendations from a BH clinician on processes or activities to be followed, then those activities should be recorded on Attachment G and must follow the recommendations of the BH clinician. If an individual has completed treatment but requires maintenance of supports, then complete Attachment G with the discharge recommendations from the clinicians and should directly align with those recommendations.
    - Attachment F is a wellness plan so anyone can benefit from having that completed. The provider should take lead and work with the individual on completing this document. If an individual with informal supports with active behavioral challenges, has informal

supports, preferences, things in place that work and have been in place for years, then complete Attachment F.

The following is provided based on questions answered during the meeting:

- Attachments are preferred to be typed, but handwritten is allowed if legible. Legibility is determined by the Support Coordinator or the LGE. The Support Coordination Agency is not required to type attachments for providers.
- Providers have five (5) days from receipt of the plan of care to submit provider attachments to the support coordinator.
- Attachment I is not required to be completed by Day Habilitation providers. They should have a staff back up plan and an emergency plan for the Day Hab.
- Providers are required to complete Attachment I, Staff Backup Plan. Support Coordinators are to complete Attachment H, Emergency Plan.
- An Information Bulletin was posted in LaSRS on May 23, 2025 providing a link to OCDD resources on the new LDH website. Once you click the link, just enter the keyword "attachment" and the OCDD provider attachments will appear.
- Support coordinators are required to provide the full plan of care and supporting documentation to providers, including Day Habilitation providers. CMS requires the provider to have the full plan of care on file.
- All attachments should be person centered.

**PROVIDER MONITORING OF PROGRESS NOTES**

OCDD issued standard progress note forms and provided training on content needed. Actions taken were a direct result of findings from the Legislative Auditor. OCDD will do provider monitoring to ensure providers are in compliance with the training provided.

OCDD will be initiating provider monitoring of progress notes. We have two monitoring groups within OCDD who will complete the monitoring process. Monitoring will begin in July 2025 and all providers will be monitored throughout the fiscal year (FY)26. Providers will receive a letter in advance notifying them of the date and time of monitoring at your agency. The monitoring will occur on site at the provider's office. OCDD has developed a standard monitoring tool that aligns with the progress note format and training shared with providers.

The monitors will use the tool and track the results. Monitoring group will come to your office and give you the names of individuals for a specific time period to review. The monitoring group will compare the progress note to the EVV record in LaSRS in addition to ensuring all required elements are present. Prior to the monitor leaving, they will provide you with informal results of the monitoring. Records requested that are not present the day of the monitoring may be provided to the monitor before they leave, but if the record cannot be produced on the day of monitoring, then it will be marked as missing. This is the only opportunity you will have to provide missing documentation.

You will receive a follow-up letter with the results of the monitoring. All providers will be monitored annually.

Scoring will be a 1, 2, or 3 similar to other tools used by OCDD.

1 – Documentation is inadequate (checklists, no details) or missing completely
2 – Documentation is available and meets the minimum requirements with improvements recommended.
3 – Documentation is person centered and well developed. No recommendations needed.

Providers who score a 1 on any element will be required to submit a Corrective Action Plan (CAP) to the OCDD monitor for that area. During this initial monitoring, the score of 1 will be for documentation that is completely missing, or hugely problematic. For missing documentation, we will provide a recommendation that you void any shift that was billed without documentation and repay any funds received for the shift. If you have check boxes and nothing in progress notes, then it will be scored a 1.

If you have to do a CAP, the OCDD monitoring group will approve the CAP. If you are required to do a CAP, you will receive a second monitoring visit within 60-90 days after the CAP is received. If the second monitoring visit reflects continued noncompliance, it is possible that we will have to make a referral to Program Integrity. Any referrals will be for egregious errors.

Documentation includes current plans of care, provider attachments, and any revisions to the plan of care. We have set this monitoring up to be reflective of the same types of things that the Louisiana Legislative Auditor (LLA) looks at when they come to monitor your agencies.

The following is provided based on questions answered during the meeting:

- The monitor will request the notes for the prior month. We expect the notes to be available in the office. It will start in July 2025 and the monitoring period will be for FY 26.

- There will be no home visits. The reviews will occur at the provider's office, so the notes need to be available in the office.

- Providers should access the following for guidance on completing progress notes:

    - Click on "Resources" and then "Document Search" - https://www.ldh.la.gov/resources
    - Enter "Provider Memo" in the "Keyword" field - https://www.ldh.la.gov/resources?cat=&d=0&y=0&s=0&q=provider%20memo
    - Click on Provider Memos to see the Power Point (PPT) and Video for Provider Documentation Requirements Training.
    - The actual forms and instructions are located at this link: https://www.ldh.la.gov/resources?cat=&d=0&y=0&s=0&q=progress%20note

- Are progress notes with an attestation for changes to the EVV signed by the supervisor and worker acceptable for edits in the LaSRS? It depends on the documentation, but if an attestation with signatures exists on the progress note to identify changes to the EVV, then it may be acceptable.

- Providers will not be fined if they are required to complete a CAP. The CAP is an opportunity for you to put together an action plan to correct the issues found. The only reason OCDD will make a

referral to PI for will be things that are egregious, and that will only be after you have been given the opportunity to fix the issues.

- Self-Direction will be monitored for progress notes in the future.

- Page 2 of the Single Shift for Single Date of Service note is optional. Page 2 of the Multiple Shift for Single Date of Service note is required.

- If you receive a 2 or 3 rating, you will receive the results of the monitoring and be scheduled for another visit the following fiscal year.

- The letter with the monitoring results will provide the due date for any CAP required.

- Electronic documents may be printed out for the monitor. It is up to the monitor if they want to review the records electronically or have them printed.

**REMINDERS**

If revision affects services delivered by a provider, then the provider must sign the revision. Do not submit annual budget pages or revisions without the provider's signature.

If DSP lives with the person they support for S5125 in-home services, then the DSP must be **related** to that individual. Funds will be recouped if DSP living with the individual is not related.

Pam Sund, OCDD Quality Program Manager wanted to thank everyone for their participation in the National Core Indicators (NCI) Adult In-Person Survey. It was a huge success as all individuals were interviewed. A big thanks to providers who assisted with setting up the interviews.

Next Provider Meeting has been **RESCHEDULED**. The next date is **Monday**, **September 29th at 10:00AM.** The AAIDD conference starts on Wednesday, September 16th, so the provider meeting has been rescheduled.