POLICY AND PROCEDURE

POLICY NAME: Organizational Assessment and Reassessment	**POLICY ID:** LA.CRED.09
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Credentialing
EFFECTIVE DATE: 08/2020	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 10/20, 10/21, 09/22, 08/23, 06/24	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This is a policy to provide an overview of the processes followed to complete all organizational assessments and reassessments.

PURPOSE:
To ensure LHCC develops and maintains a network of healthcare delivery organizations and, as applicable to market-specific requirements, Managed Long-Term Services and Supports (MLTSS) organizations ("providers") qualified to meet the health care, long-term care (LTC), and home and community-based services (HCBS) needs of covered members in an efficient, compliant, safe, and effective manner.

SCOPE:
This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company"). Louisiana Healthcare Connections Credentialing ("Credentialing") and Provider Data Management ("PDM") on behalf of Louisiana Healthcare Connections ("LHCC"). Provider Network Specialists and Network Contracting Departments.

DEFINITIONS: None

POLICY:
Louisiana Healthcare Connections has established standards for conducting the functions of provider selection and retention. These standards include practices for provider assessment and reassessment that meet the qualifications of applicable state and federal government regulations and applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of the state.

Network Participation: For consideration to participate in the LHCC network, all providers who have an independent relationship with LHCC must complete an application for participation, submit copies of applicable supporting documentation, and meet the participation requirements of LHCC.

It is the sole responsibility of the applicant to produce all necessary information and documentation in a timely manner as required to conduct a thorough examination. Failure to provide the necessary information within thirty (30) calendar days from the initial application date may result in termination of the process. If the provider ever seeks to join LHCC in the future once the process has been terminated, the provider must begin the process from inception.

A. Types of Providers:
LHCC may include, but is not limited to, the following medical, behavioral health care, and MLTSS providers in its contracting efforts:

- Hospitals, home health agencies, skilled nursing facilities, federally qualified health centers, rural health clinics, laboratory testing/diagnostic facilities, rehabilitation centers and free- standing surgical centers;
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or in an ambulatory setting; and
- Other atypical MLTSS providers including Home and Community Based Services (HCBS) and long-term care (LTC) institutional-based services Providers.
    - These atypical providers may not have a license and/or NPI.

B. Assessment:
Assessment must be performed for hospitals, home health agencies, skilled nursing facilities and free-standing surgical centers, and inpatient, residential, and ambulatory behavioral health facilities. Assessment may be performed for other provider types based upon state and federal regulations and State Contract requirements.

C. Reassessment:

Where assessment is required, Credentialing formally reassesses providers at least every thirty-six (36) months. The reassessment cycle begins with the date of the initial credentialing decision.

Binding Nature of Credentialing Committee Decisions: LHCC has the right to make the final determination about which providers subject to Credentialing Committee review may participate within its network.

PROCEDURE:

I. Practitioner Rights

All practitioners are notified of their right to review information obtained by LHCC to evaluate their credentialing or recredentialing application upon receipt of a written and signed request submitted to the Credentialing Department. These rights do not include the right to review references, personal recommendations, or other information that is peer review protected. Practitioners also have the right to receive the status of their credentialing or recredentialing application at any time by contacting the Plan Provider Relations and/or Contracting Department. Should the practitioner believe any of the credentialing information to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, he/she has the right to correct any erroneous information submitted by another party.
New practitioners who are denied participation for non-administrative reasons have the right to request a reconsideration of the decision within thirty (30) calendar days of the date of receipt of the denial letter.
Notification of these rights may occur via individual correspondence, in the provider manual, and/or on LHCC's web site.

~~I.~~II. Application Received

A. LHCC contracting secures first-signature contracts, provider applications, and associated documents from applicant providers and forwards to PDM.
B. PDM verifies existence of sufficient information needed for enrollment:
    i. Hospital/Ancillary Provider Credentialing Application Completed not more than 1 year prior to enrollment;
    ii. Copy of current State Operational License
    iii. Other applicable current State/Federal/Licensures (i.e. CLIA, DEA, Pharmacy, or Department of Health)
    iv. Copy of current Accreditation/certification (by a nationally recognized accrediting body, i.e. The Joint Commission)
        a. If not accredited by a nationally recognized body, Site Evaluation Results by a government agency.
    v. Copy of Current General Liability coverage (document showing the amounts and dates of coverage), or
    vi. Attestation of current professional liability coverage in the minimum amounts of $1,000,000 per occurrence and $3,000,000 aggregate, or as otherwise set forth by LHCC. Copy of current Medicaid Certification (if not certified, provide proof of participation), if required
    vii. Applicable W-9(s)
    viii. Query of the National Plan & Provider Enumeration System (NPPES) to confirm that the provider has a current, valid, unique National Provider Identifier (NPI) for every provider type, to the extent such provider is not an atypical provider as defined by CMS
    ix. Current Disclosure of ownership or financial interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, home health, or other business dealing with the provision of ancillary health services, equipment or supplies;
        a. The Disclosure forms are forwarded to the Compliance department for monitoring of exclusions as specified in LA.COMP.27.
        b. Upon notification from the Compliance department of a verified exclusion status of an individual or entity with an ownership or controlling interest in the provider or a managing employee of the provider, PDM will initiate the appropriate actions specified in the State contract, up to and including termination of the contracting process or participation status.
C. In conjunction with the enrollment process, if state requirements specify, PDM also performs additional reviews to ensure compliance to requirements in the provider contract.
    i. Eligibility to become a Medicaid provider is verified as part of enrollment, as applicable per State requirements;
D. If any of the required items needed for enrollment are missing or insufficient, PDM notifies Contracting or Provider Relations to secure needed items.
E. Upon completion of enrollment into the Provider Data Management system, documentation is forwarded to Credentialing.

~~II.~~III. Verification of Items Requiring Primary Source Verification (PSV)

Credentialing verifies using primary sources the elements included in this section. Primary sources may include oral, written, and/or internet sources. Any sources used are NCQA accepted.

Query images and other documentation reviewed (including those retrieved via oral sources) during PSV are saved, date stamped, initialed, and placed in the applicant's file prior to network participation.

A. Medicare/Medicaid-specific exclusions or NPDB reports.
    i. OIG will be queried through the Office of Inspector General's website
    ii. State Specific Exclusion Lists, as applicable; The Louisiana DHHS Adverse Actions List shall be queried.
B. Determination if a provider has been debarred, suspended, or otherwise excluded from participating in federal procurement activities
    i. The System for Awards Management (SAM) website, formerly EPLS, shall be queried.

~~III.~~IV. Verification of Items Where PSV is Not Required

The elements below may be verified via secondary sources to support completion of an application and to show eligibility of provider to participate in the network. Documentation reviewed during verification is saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. Secondary sources of information are acceptable for the below participation requirements.

A. Current, unrestricted state license or certification to provide medical services. State-specific requirements may exist and are included in the Appendix. Acceptable verification sources include:
    i. A provider-submitted copy of the actual license/certification, or
    ii. Via PSV through the applicable state licensing or certification board
B. Proof of general liability coverage. Acceptable sources to verify existence, currency, and amount include:
    i. A copy of the face sheet of the professional liability coverage in the minimum amounts of $1,000,000 per occurrence and $3,000,000 aggregate, or as otherwise set forth by the State; or
    ii. Attestation of professional liability coverage in the minimum amounts of $1,000,000 per occurrence and $3,000,000 aggregate, or as otherwise set forth by the State; or
    iii. Federal coverage through the Federal Torts Claims Act may be confirmed by a copy of the Federal Tort letter or an attestation from provider of Federal Tort coverage. The application does not need to contain the current amount of malpractice insurance coverage; or
    iv. Evidence of compliance with state regulations
C. Letter of accreditation by an acceptable accrediting institution, as applicable. Louisiana Healthcare Connections-recognized accreditations include, but are not limited to, the following:

AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities
AAAHC	Accreditation Association for Ambulatory Health Care
ABCPO	American Board for Certification of Prosthetics and Orthotics
ACHC	The Accreditation Commission for Health Care
ACR	American College of Radiology
AOA	American Osteopathic Association
CARF	Commission on Accreditation of Rehabilitation Facilities
CCAC	Continuing Care Accreditation Commission
CHAP	Community Health Accreditation Program
CLIA	Clinical Laboratory Improvement Amendment certification
COA	The Council on Accreditation
HFAP	Healthcare Facilities Accreditation Program
NABP	National Association of Boards of Pharmacy
NBAOS	The National Board of Accreditation for Orthotic Suppliers
NCQA	National Committee for Quality Assurance
URAC	URAC, formerly known as Utilization Review Accreditation Commission
DNV/ NIAHO	Det Norske Veritas/ National Integrated Accreditation for Healthcare Organizations
TJC	The Joint Commission (formerly known as JCAHO – Joint Commission on Accreditation of Healthcare Organizations)

D. Prior to subcontracting, LHCC shall follow LDH policy in requiring agencies offering Mental health rehabilitation services (CPST, PSR and/or CI), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation or proof that the applicant applied for accreditation and paid the initial application fee for one of the national accreditation organizations listed below. New agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with:

The Council on Accreditation (COA); The Commission on Accreditation of Rehabilitation Facilities (CARF); or The Joint Commission (TJC). CPST and PSR Providers must be accredited by CARF, COA or TJC. Accreditation is required for this provider type, Site Survey (CMS or State) is not an acceptable alternative.

i. If provider is not accredited, a current "Centers for Medicare and Medicaid Services" (CMS) or state review certificate, site survey, or letter is accepted in lieu of a formal site visit, and can be utilized to augment the information required to assess compliance with LHCC standards. When credentialing providers or provider types designated by CMS as "moderate" or "high risk", a review of proof of active enrollment in Medicare will be reviewed. Active enrollment in Medicare demonstrates that the provider has undergone a fingerprint-based background check and site visit within the previous five (5) years. The CMS or state review cannot be more than three (3) years old at the time of verification.

ii. If neither of the above apply, Provider Relations staff may perform an onsite evaluation per Section IV below.

E. Evidence of CLIA Certificate or Waiver for the provision of laboratory services, as applicable per LHCC requirements.

F. If MLTSS providers are included in the network and one or more applicable participation criteria are not applicable to a specific provider, at a minimum, these MLTSS providers must complete an attestation form provided in the Appendix. The attestation form may require state approval before it can be utilized.

G. LHCC maintains documentation that it assessed contracted providers. An example of an NCQA-compliant Facility Credentialing Spreadsheet Log is provided in the Appendix.

~~IV.~~V. On-Site Evaluations

A. LHCC Provider Relations staff performs an on-site evaluation when providers are non-accredited and have not been surveyed by the state or CMS within the last three years. (Site visits are not required of non-accredited providers if the state or CMS has not conducted a site review of the provider and the provider is in a rural area, as defined by the U.S. Census Bureau.)

i. LHCC will conduct an on-site evaluation for, at a minimum, the following provider types:

a. Hospitals;
b. Home Health Agencies;
c. Skilled Nursing Facilities;
d. Nursing Homes;
e. Free-Standing Surgical Centers;
f. Behavioral Health (BH) Residential Facilities;
g. BH Inpatient Facilities; and
h. BH Ambulatory Facilities.
i. Assisted Living Facilities
j. Applicable Community Benefit Providers to ensure all applicable HCB setting requirements are met

ii. The on-site evaluation for each provider type is based on state and federal requirements and NCQA standards and includes, but is not limited to:

a. Review of provider's quality improvement program for adequate mechanisms to identify and manage situations involving risk, and assesses medical record keeping practices;
b. Review of the mechanism and policies to credential its practitioners to determine if Credentialing should individually credential; and
c. Review of physical plant/ safety information/ physical accessibility.

~~V.~~VI. Reassessment

The intent of this section is to provide clarity on which department/team is responsible for collection of the application. The list to define complete application is the same as found in Procedure I:

A. Credentialing secures documentation needed for the reassessment process; and

i. A new Provider Application is not required for reassessment if all needed information is available for reassessment

B. Credentialing secures a current Disclosure of Ownership/Interest Form, signed, and dated.

C. The reassessment process considers provider-specific performance data such as those collected through the quality improvement program, the utilization management system, the grievance/complaint system, satisfaction surveys, and other activities of the organization, and that includes an attestation to the correctness and completeness of the new information. The credentialing designee gathers applicable performance data from the QI Department designee for inclusion in the reassessment file.

~~VI.~~VII. Complete Application Criteria

A “complete application” contains all of the information needed for credentialing review, including:

A. the provider’s correctly and fully completed application; and
B. submission of all required and current assessment documents;

The application must be considered complete for credentialing review to occur. The date the application is deemed complete is recorded within the Provider Data Management system.

~~VII.~~VIII. Process to Secure Missing and/or Expired Information

Missing and/or expired information must be secured from the provider before an application can be considered complete.

A. Credentialing and/or LHCC staff contact the provider to secure missing and/or updated documentation.
    i. If information is not secured within thirty (30) calendar days, Credentialing and LHCC determine course of action up to and including termination of the application process.
    ii. If application is terminated, notification is sent to the provider.

~~VIII.~~IX. Minimum Administrative Requirements

Certain minimum requirements must be met for participation review to occur; if these requirements are not met, termination of the process results and is referred to as “administrative” termination of the application process.

A. Minimum administrative requirements that must be met include:
    i. Contains the minimum elements required for verification as described in Sections II-III of this document;
    ii. Does not contain information that the provider has been excluded from participation in the Medicare and/or Medicaid program or state-specific exclusions.
    iii. Does not contain information that the provider does not meet state-specified contractual requirements, e.g., CLIA certification or waiver.
B. Credentialing notifies the provider via certified mail of the administrative termination of the application process.
    i. A copy of the letter is retained in the provider’s closed file and maintained in the Credentialing Department for future reference.
C. When administrative requirement (ii) is not met, Credentialing notifies LHCC and PDM to ensure appropriate actions are taken:
    i. As applicable, PDM modifies Provider Data Management system to prohibit payment to providers under these programs.
    ii. Compliance ensures applicable State notifications are completed.

~~IX.~~X. Determination and Review of Clean Files

Applicants for whom Credentialing Committee review is required who meet the participation criteria upon initial and/or reassessment and are determined to have a “clean file” are approved for participation following review by the Medical Director or chair of the Credentialing Committee. Provider types are defined in NCQA standards undergo Credentialing Committee review. These providers include: Hospitals, Home Health Agencies, Skilled Nursing Facilities, Free-Standing Surgical Centers. LHCC shall notify LDH of denial of a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of Providers to participate for program integrity-related reasons.

A. LHCC defines a “clean file” as one that meets the following criteria:
    i. Current general liability coverage in the amount required by LHCC;
    ii. No past or present Federal or State sanction activity including Medicare/Medicaid sanctions; and/or
    iii. Site visit score must meet the established threshold, if site visit is applicable.
B. If a file is determined to be clean, the provider is presented to the Medical Director or chair of the Credentialing Committee on a summary listing containing, at minimum, provider name and NPI.
    i. Information is typically presented via email but may also be presented in person.
    ii. Approval is typically received via email. An e-mail approval sent from an appropriately authenticated e-mail account is considered a valid approval source.

~~X.~~XI. Committee Review of Unclean Files

Initial and/or reassessment files that do not meet criteria for clean file review are brought to the Credentialing Committee for review. The Credentialing Committee has been delegated the responsibility from the Quality Improvement Committee to review the qualifications of each applicant presented and make approval or rejection determinations

A. If the Credentialing Committee requires additional information prior to making a determination, application may be pended. Outreach is made to secure additional information and once obtained, the file presented to Credentialing Committee at a future meeting.
B. The Credentialing Committee may determine that corrective action is necessary in order to credential a provider. The Committee decision includes a description of the steps necessary to fulfill compliance with the required action. If necessary, a work process will be created to document the specific step-by-step detail of how to complete the required tasks. Provider application should be pended, and a future date set for re-review.
    i. The applicant is sent notice of its status in writing within sixty (60) calendar days of the Credentialing Committee decision.

~~XI.~~XII. Denial of Credentialing Application

A. Medical Director or Credentialing Committee may decide not to extend participation status to a provider.
    i. The Credentialing Committee Chair or designee notifies the provider via certified mail of the Credentialing Committee denial decision within sixty (60) calendar days of the Credentialing Committee's decision.
    ii. A copy of the letter is retained in the provider's closed file and maintained in the Credentialing Department for future reference.
    iii. New and existing Organizational Providers who are denied participation for non-administrative reasons have the right to request a reconsideration of the decision within thirty (30) calendar days of the day of receipt of the denial letter.
    iv. Notification of these rights may occur via individual correspondence, in the provider manual, and/or LHCC's website.
    v. Binding Nature of Credentialing Decisions: LHCC has the right to make the final determination about which Organizational Providers may participate within its network. Practitioners who are denied initial participation may reapply for admission into the network no earlier than one (1) year following the initial denial or end of the reconsideration process.

~~XII.~~XIII. Unique Organizational Assessment Requirements

1. Louisiana Healthcare Connections shall notify LDH of denial of a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of Providers to participate for program integrity-related reasons.
2. Louisiana Exclusion Database (LED) shall be queried.
3. Prior to subcontracting, LHCC shall follow LDH policy in requiring agencies offering Mental health rehabilitation services (CPST, PSR and/or CI), Assertive Community Treatment Act (ACT), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation by an LDH approved accrediting body, which shall be made part of the agency's credentialing file. Agencies not accredited at the time of credentialing shall supply proof that the applicant applied for accreditation and paid the initial application fee for one of the national accreditation organizations listed below. New agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date. Specialized Behavioral Health provider types required to be accredited by rule, regulation, waiver, or State Plan Amendment (SPA) prior to contracting or prior to receiving Medicaid reimbursement, shall have proof of accreditation on file with Louisiana Healthcare Connections. LDH approved national accrediting bodies include: The Council on Accreditation (COA); The Commission on Accreditation of Rehabilitation Facilities (CARF); or The Joint Commission (TJC). CPST and PSR Providers must be accredited by CARF, COA or TJC. Accreditation is required for this provider type, Site Survey (CMS, State or Health Plan) is not an acceptable alternative.
4. The Louisiana Adverse Actions List shall be queried.
5. LHCC shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c- 5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings:
    - Revocation of the provider's home and community-based services license or behavioral health service license;
    - Exclusion from the Medicaid program;
    - Termination from the Medicaid program;
    - Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41);

- Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or
- The Louisiana Attorney General's Office has seized the assets of the service provider.

6. LHCC shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.
7. LHCC will verify that providers are properly credentialed to deliver Evidence Based Practices (EBP).
8. Health plan(s) operating in the State of Louisiana require individual providers to meet professional liability insurance in the minimum limits of: $100,000 per occurrence $300,000 aggregate OR Enrollment in the Louisiana Patients' Compensation Fund.

REFERENCES:
Current NCQA Health Plan CR Standards and Guidelines
CMS Medicare Managed Care Manual Chapter 6 "Relationships with Providers"
LDH Model Contract Sections 2.9.4.1.4-2.9.4.1.5

ATTACHMENTS:
A. Example Facility Credentialing Spreadsheet Log
B. Atypical Provider Attestation Form
C. Atypical Providers Listing

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
HB 434, Act 319 applies to material changes to this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Converted corporate to local policy	10/2020
Annual Review	Reviewed for submission approval	10/2021
Annual Review	Formatting edits	09/30/22
Annual Review	Merged into new policy template, added policy statement; Incorporated edits from Corporate Credentialing: CMS risk assessment when PSV not required; Added liability insurance limits for Unique Organizations; Updated language for reconsideration/appeal for new/existing organizational providers who were denied by credentialing committee during initial or re-credentialing process Updated Product from "All" to "Medicaid" Removed "Medicare" from section I,B,vi	08/08/23
Annual Review	Added language from Corporate	06/2024

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

Attachment A

Example Facility Credentialing Spreadsheet Log

Name of Organization	Type of Organization	Prior Validation Date/License Status	Current Validation Date/License Status	Prior Accred Validation Date/Body/ Status	Current Accred Validation Data/Body/ Status	Prior Site Visit Date/ Status	Current Site Visit Date/ Status
ABC Hospital	Hospital	NA	10/26/2009; Active	NA	10/26/2009; JCAHO; Active	NA	NA
Downtown Surgery Center	Free-Standing Surgical Center	3/30/2004; Active	3/15/2007; Active	None	None	2/2/2004; CMS Compliant	2/10/2007; CMS Compliant
District Physicians	Home Health	3/2/2004; Active	3/17/2007; Active	(name)/Active	3/20/2004/; Name; Active	NA	NA

Attachment B

Atypical Provider Attestation Form
Attestation Statement

INSTRUCTIONS: Please complete either Section A *or* Section B for consideration to participate in the Health Plan provider network. For any "Yes" response to one or more of the questions in Section B, complete the attached Attestation Question Explanation Form.

This attestation pertains to all employed and contracted provider(s) authorized to provide or supervise care provided by (the "Agency").

I, , the undersigned representative of Agency, on its behalf, understand and agree that as part of the credentialing process for participation in the Health Plan provider network,

Section A
…attest that the Agency has conducted the following on each caregiver prior to allowing each to provide care to a Health Plan member:

☐
- Criminal Background Check *and*;
- State Child Abuse Registry *and*;
- Other State Mandated Clearance Checks

Section B
…assure through a background check and other reasonable means the following with respect to each caregiver providing care and each attendant supervising care on behalf of the Agency:

☐	YES	☐	NO	1.	Have applicable license(s) held by caregiver(s) and/or attendant(s) been revoked, refused, restricted or voluntarily surrendered?
☐	YES	☐	NO	2.	Have caregiver(s) and/or attendant(s) been convicted of, or pled guilty to, a felony?
☐	YES	☐	NO	3.	Has any caregiver or attendant been terminated, suspended, barred, sanctioned or voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program?
☐	YES	☐	NO	4.	Is/Are caregiver(s) and/or attendant(s) unable to perform the essential functions of his or her job with reasonable accommodation?
☐	YES	☐	NO	5.	Is the Agency aware of any reason why caregiver(s) and/or attendant(s) may pose a threat to the person or property of individuals receiving care provided by caregiver(s) or supervised by attendant(s)?

Signature: _____

Print: _____

Title: _____

Date: _____

Tax ID: _____

Attachment C

Atypical Providers Listing

Adult Day Health
Adult Foster Care
Assessment Service
Assistive Care Services
Assistive Services - TBI
Assistive Services - IDD
Assistive Services - Physical Disability
Assistive Technology -Frail and Elderly
Attendant Care
Attendant Care - Level I
Attendant Care - Level II
Behavior Therapy
Behavioral Management
Caregiver Training
Case Manager
Cognitive Therapy
Community Transition
Comprehensive Support - Provider Directed
Day Supports
DD Programs (DD Day Care Programs)
DME and Appliances
Emergency Transportation
Enhanced Community Living
Family Adjustment Counseling
Habilitation
Health Maintenance Monitoring
HIS Out-Patient Services
Home and Community Based Services (Other)
Home Care Attendant
Home Health Aid Service
Home Health Nurse Service
Home medical equipment and supplemental adaptive and assistive devices
Home Modification
Homemaker
Hospice Home Care
Hospice inpatient Care
Independent Case Management
Independent Living Assistance
Independent Living Counselor
Inpatient Hospital (RM&BD and Ancillary)
Intensive individual Supports
Intermittent Intensive Med Care
Long-Term Community Care Attendant - Agency Directed
Long-Term Community Care Attendant - Self Directed
Medical Respite
Medical Supplies
Mental Health Services
Non-Emergency Transportation
Nursing Facility Care
Out-Patient Facility Fees
Personal Assistant Services
Personal Care
Personal Service Attendant
Personal Services
Personal Services - PDPSA
Personal Services - PDPSS
Personal Services - Physical Disability
Rehabilitation
Respiratory Therapy
Respite Care - Autism
Respite Care - Frail and Elderly
Respite Care - Home and Community Based Services
SNF
Specialized Medical Care - RN
Specialized Medical Care - LPN
Specialized Services
Supportive Living Facility
Transitional Living Skills
Vocational Habilitation
Wellness Monitoring