



EPSDT – Targeted Population

Support Coordination Training



Purpose of the Training:

To establish a uniform training module for the Support Coordination agency's Designated Trainer and Supervisors to use in conjunction with the Support Coordination Training Handbook.

This Training Module will be used:

- For new support coordinators, supervisors and trainers hired to serve the EPDST – Targeted Population as part of the 16 hours of orientation training.
- For existing EPDST support coordinators, supervisors and trainers as part of the 20 hours of annual training.
- As reference material for support coordinators and supervisors.



Documents Required For Training

- EPSDT – Targeted Population Support Coordination Training Handbook & Appendices

- EPSDT Training Module –
 - Part 1 – EPSDT-Targeted Population
 - Part 2 - Medicaid Managed Care Program
 - Part 3 - COVID-19 Exceptions

An electronic copy of the Handbook has been given to each agency. The PowerPoint presentation will be e-mailed to each agency after completion of the training along with clarification of questions and answers. The Handbook contains more detailed information than is provided in this presentation.



Part 1

EPSDT-Targeted Population



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.



Chisholm Class Members

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



EPSDT Support Coordination 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 9 and 49 of the EPSDT Targeted Population Support Coordination Training Handbook for additional criteria.



Important Information About Medicaid Services

- Legacy Medicaid
 - Traditional Medicaid for people who are not enrolled in a Managed Care Organization for most of their health services.
 - Chisholm class members have the option of staying in Legacy Medicaid for their physical health services.



Important Information About Medicaid Services

- Medicaid Managed Care Program
 - Managed care system for physical health, specialized basic behavioral health and non-emergency medical transportation services.
 - Covers 950,000 Louisianans.
 - Five managed care organizations (MCOs) working statewide:
 - Aetna
 - Amerihealth Caritas Louisiana
 - Healthy Blue
 - Louisiana Healthcare Connections
 - United Healthcare Community Plan



Important Information About Medicaid Services

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



Chisholm Class Members in the Medicaid Managed Care Program

- **Physical Health Services**

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



Chisholm Class Members in the Medicaid Managed Care Program

■ **Behavioral Health Services**

- Chisholm Class Members are required to enroll in a Managed Care Organization for specialized behavioral health services. If they are enrolled in the Coordinated System of Care Waiver (CSoC) most of their specialized behavioral health services will be accessed through Magellan.

■ **Transportation Services**

- Chisholm Class Members are required to enroll in a Managed Care Organization for non-emergency medical transportation.



Medicaid Eligibility Verification

- Support coordinators are required to validate EPSDT beneficiaries Medicaid eligibility through MEVS/REVS or e-MEVS at the beginning of every month.
- The Medicaid Eligibility Verification will provide the SC with current information on the beneficiary's Medicaid coverage including their Managed Care Organization's information.



Services Available to EPSDT Beneficiaries



Services Available to EPSDT Beneficiaries

- Children and youths receiving targeted EPSDT Support Coordination are eligible to receive all medically necessary **Medicaid services** that are available to people under the age of 21.
- In addition if they are placed on the DD RFSR, they may be eligible for services through the Louisiana **Developmental Disabilities services system**, administered by the Office of Citizens with Developmental Disabilities (OCDD) through the Human Services Districts and Authorities.
- Services through the **Office of Behavioral Health** are available for children and youth with emotional disturbances.
- Children and youth may be able to receive services through the **school system** or through Early Childhood Education programs.



Medicaid Services Available to EPSDT Beneficiaries

- Beneficiaries under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures covered under federal Medicaid statutes and regulations to correct or improve physical or mental conditions. Services may include those not otherwise covered by Louisiana Medicaid for beneficiaries age 21 and older, unless prohibited or excluded.
- For a listing of Medicaid services, consult the **Medicaid Services Chart** (*Appendix B*). 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 beneficiary who is under age 21.
- Children 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.



Medicaid Services Available to EPSDT Beneficiaries

- No generally fixed limits – Beneficiaries 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.



Medicaid Services Available to EPSDT Beneficiaries

- Non-emergency Medical Transportation
- Mental Health Rehabilitation
- Medical, dental, vision and hearing screenings, both periodic and interperiodic
- Applied Behavioral Analysis (ABA)
- Personal Care Services (PCS)
- Home Health Services
- Pediatric Day Health Care (PDHC)
- Physical therapy
- Occupational therapy
- Speech and language evaluations and therapy



Medicaid Services Available to EPSDT Beneficiaries

- Audiology Services
- Hearing aids and Psychological Evaluation and Treatment
- Medical Equipment and Supplies (DME)
- Disposable incontinence supplies
- supplies needed for them
- Eyeglasses and/or contact lenses
- Nutritional supplements needed for growth or nourishment
- Any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice



Medicaid Services Available to EPSDT Beneficiaries

- 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 Available to EPSDT Beneficiaries

- A Support Coordinator develops a full list of all the services a beneficiary needs and then helps them get and coordinate these necessary services.
- Parents often do not understand aspects of the Medicaid system. Therefore, one of the primary responsibilities of the Support Coordinator is to follow through with requests for services until the Prior Authorization is either approved or denied based on medical necessity and when approved, make sure the services are provided as authorized.



Medicaid Services – Physical Health

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



Locating Providers for Physical Health Services - 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 beneficiaries and to help identify needed sources for referrals that may otherwise be difficult to find.
- The Specialty Care Resource Line is supported by an **automated resource directory** of all Medicaid-enrolled providers of medical services, including physicians, dentists, mental health clinics, and many other health care professionals. The database is updated regularly.



Locating Providers for Physical Health Services - Legacy Medicaid

- A list of available providers is available through the Medicaid website at www.medicaid.la.gov.
- Click Locate a Provider, select the service need you're looking for under Provider Groups & Provider Specialties, and select the region or parish where the beneficiary lives.
- The direct website address to find a provider is: https://www.lamedicaid.com/apps/provider_demographics/provider_map.aspx



Locating Providers for Physical Health Services - Medicaid Managed Care

- Support Coordinators should assist with locating a provider contracted with their MCO.
- Resources for locating providers include:
 - Online Provider Directory at www.myplan.healthy.la.gov.
 - Select Choose > Find a Provider.
 - Choose 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 (*Medicaid Managed Care Appendix B*)
 - Access MCO websites to identify contracted providers.



Medicaid Services – Behavioral Health

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



Locating Behavioral Health Providers - Medicaid Managed Care

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



Locating Behavioral Health Providers - Magellan

- If a beneficiary is enrolled in the Coordinated System of Care (CSoC), they can access specialized behavioral health services by contacting Magellan at 1-800-424-4489/TTY 1-800-424-4416.
- Their wraparound facilitator can also assist with accessing specialized behavioral health services.



Medicaid Services – Transportation Services

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



Locating Providers

- If you are unable to locate providers for a Chisholm Class Member call the contact person listed on the Medicaid Services Chart (*Appendix B*) for assistance. Make sure you contact the correct Program Subject Matter Expert when information is needed (i.e. DME staff for DME related services, etc.)
- Call the LDH Program Staff Line for providers if the service contact person is unable to assist at 1-888-758-2220.
- For beneficiaries in the Medicaid Managed Care Program, their MCO should be contacted rather than those on the Medicaid Services Chart. Refer to slide 201. Since the MCO must cover at least as much as Legacy Medicaid, the Medicaid Services Chart can still be helpful reference.



Applied Behavioral Analysis (ABA)

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



Applied Behavioral Analysis (ABA)

- For Medicaid to cover ABA services through a licensed provider the person must:
 - Be under the age of 21
 - Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include: aggression, self-injury, elopement, etc.)
 - Be diagnosed by a qualified health care professional with a condition for which ABA-based therapy are recognized as therapeutically appropriate, including autism spectrum disorder.
 - Have a comprehensive diagnostic evaluation (CDE) by a qualified health care professional and have a prescription for ABA-based therapy services ordered by a qualified health care professional. (A separate prescription is not needed if the CDE recommends ABA.)



Applied Behavioral Analysis (ABA)

- To find an ABA Provider in your area, call the Managed Care Organization of the beneficiary. Refer to *Medicaid Managed Care Appendix B*.
- If a beneficiary wants to see if they qualify for ABA, contact the beneficiary's MCO and complete a referral for a Clinical Diagnostic Evaluation (CDE).
- For more information on ABA contact the beneficiary's MCO (*Medicaid Managed Care Appendix B*) or LDH directly at 1-844-423-4762 and refer to pages 15-16 of the EPSDT SC Handbook.



Transportation Services

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



Transportation Services

- Transportation must be provided in all parishes and to all eligible beneficiaries. If there is a need for special arrangements, such as lift-equipped transportation, the MCO must insure that such arrangements are made promptly so that the beneficiary can obtain the medical services they need.
- The role of the Support Coordinator is to assist the beneficiary in arranging transportation services for the beneficiary.
- The transportation phone numbers for each MCO can be found on *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 beneficiary’s friend or family member to take them to medical appointments when certain conditions are met.
- Gas Reimbursement providers may not reside at the same address as beneficiaries that they transport and beneficiaries cannot be reimbursed for transporting themselves to appointments.
- To assist someone you are serving that may benefit from this arrangement contact the beneficiary’s MCO (*Medicaid Managed Care Appendix B*).



Medicaid Services Available to EPSDT Beneficiaries

Behavioral Health Services



Mental Health and Substance Use Services

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

- Psychiatrist visits
- Individual, family, and group therapy
- Mental Health Rehabilitation
- Assertive Community Treatment
- Functional Family Therapy
- Homebuilders
- Multi-Systemic Therapy
- Substance Use Disorder treatment
- Psychiatric hospital
- Psychiatric Residential Treatment Facility
- Therapeutic Group Home
- Crisis Stabilization



Mental Health and Substance Use Services

Mental Health Rehabilitation (MHR) services include:

- Community Psychiatric Support and Treatment (CPST)*
- Psychosocial Rehabilitation (PSR)*
- Crisis Intervention (CI)

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

Note: CSoC enrollees will access these services through Magellan. Services through Magellan do not require PA tracking by SC.



Mental Health and Substance Use Services

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



School-Based Behavioral Health Services

- Medicaid also funds behavioral health services provided through schools or early childhood educational settings for children ages 3 to 21 years, such as regular kindergarten classes; public or private preschools; Head Start Centers; child care facilities; or home instruction. To be funded by Medicaid, these services must be included in the child's Individualized Education Program (IEP).
- Behavioral Health services, treatment, and other measures to correct or ameliorate an identified mental health or substance use disorder diagnosis may be provided by licensed mental health practitioners or Louisiana Certified School Psychologists and Counselors.



Coordinated System of Care (CSoC)

- CSoC was developed for Louisiana's children and youth with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement.
- CSoC offers an array of Medicaid State Plan and Home and Community-Based Waiver services (HCBS) to children and youth in need of mental health and/or substance use treatment who are deemed clinically and financially eligible.
- CSoC is an evidence-informed approach that enables children to successfully live at home, stay in school and reduce involvement in the child welfare and juvenile justice systems.



Coordinated System of Care (CSoC)

- CSoC might be right if the child:
 - Is 5 - 20 years old,
 - has a mental health or co-occurring disorder,
 - has a history with child welfare, juvenile justice and/or trouble in school, and
 - is in an out-of-home placement, or at risk for being placed out of home including:
 - Substance Use Disorder treatment facilities
 - Detention
 - Developmental disabilities facilities
 - Homeless (as identified by the Department of Education)
 - Non-medical group home
 - Psychiatric hospitals
 - Psychiatric residential treatment facilities
 - Secure care facilities
 - Therapeutic foster care
 - Therapeutic group home



Coordinated System of Care (CSoC)

- Partners play a very important role in the success of CSoC. CSoC intends to ensure that efforts on behalf of children and families are integrated across systems. CSoC is a family driven process. Therefore, referrals should be made with parent's/guardian's knowledge, consent and participation.
- To make a referral for CSoC:
 - Contact the beneficiary's Managed Care Organization with the parent/guardian present or on the phone.
 - The Managed Care Organization will ask initial risk questions and transfer the call to Magellan if the child meets criteria.
 - Magellan will conduct a brief Child and Adolescent Needs (CANS) assessment to establish preliminary eligibility.



Coordinated System of Care (CSoC)

- If, based on the brief CANS assessment, a child/youth is eligible for CSoC, Magellan will:
 - refer the child or youth to a **Wraparound Agency** to: ensure that a comprehensive assessment is completed, offer the child/youth and the family an opportunity to participate in CSoC and begin forming a child and family team.
 - refer the child or youth to a **Family Support Organization** to support the child or youth and their family.
- Regardless of CSoC eligibility, their Managed Care Organization will ensure that the child or youth is referred to providers who can meet their needs.



Coordinated System of Care (CSoC)

- Children and youth enrolled in CSoC are assigned a worker called a **Wraparound Facilitator**. The child and family will work with the facilitator to develop a plan of care with a team of people. The plan can include services and supports to meet their behavioral health needs as well as other needed services and supports that affect their wellbeing.
- Coordinated System of Care (CSoC) enrollees may receive these **additional** services:
 - Parent Support and Training
 - Youth Support and Training
 - Short Term Respite Care
 - Independent Living and Skills Building
- If a beneficiary is part of Coordinated System of Care (CSoC), they can access specialized behavioral health services by contacting **Magellan** at 1-800-424-4489/TTY 1-800-424-4416.



Medicaid Services Available to EPSDT Beneficiaries

Physical Health Services



EPSDT Screening Exams and Checkups

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



EPSDT Screening Exams and Checkups

- In addition, an **interperiodic screen** can be obtained whenever one is requested by the parent or recommended by a health, developmental, or educational professional (including a Support Coordinator) in order to determine a child's need for health treatment or additional services.



EPSDT Screening Exams and Checkups

- When detected early medical conditions such as lead poisoning, sickle cell anemia, developmental delays, nutritional deficiencies, and behavioral disorders consistently result in successful outcomes and cost effective treatment plans.
- PCPs are responsible for making appropriate referrals when needed based on the results of a screening.



Personal Care Services

- Personal Care Services (PCS) are provided by direct service workers and defined as tasks that are medically necessary as they pertain to an EPSDT beneficiary's physical requirements when cognitive or physical limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements. Assistance is provided with meal preparation if the beneficiary is on a restricted diet that differs from the rest of the household members and no family member is preparing the meals.
- PCS **does not include medical tasks** such as medication administration, tracheotomy care, feeding tube or catheter requirements. Assistance with these tasks can be covered through Medicaid's Home Health program. Refer to *Appendix E* for PCS Rule information and for a comparison of PCS and Home Health Services.
- PCS **is not intended as a substitute for child care needs or to provide respite care to the primary caregiver.** A parent or adult caregiver is **not required** to be in the home while services are being provided to children.



How is PCS authorized?

- Personal Care Services must be prior authorized by Gainwell Technologies (Legacy Medicaid) or the MCO (Medicaid Managed Care Program)
- The provider must complete a Social Assessment form, a daily time schedule and develop a plan of care.
- A practitioner must complete an EPSDT-PCS Form 90 to prescribe or refer the service, and sign the provider's plan of care.
- The number of hours approved is based on assistance with the personal care needs that are covered through this program. There are **no set limits** to the number of hours a beneficiary can receive.
- The Support Coordinator should assure that the practitioner has all critical information before the services are prescribed.
- All PA requests should include necessary documentation to support the medical necessity of the request.



How do I find a PCS provider? – Legacy Medicaid

- Personal Care Services must be prior authorized by LDH's Fiscal Intermediary, Gainwell Technologies. Service must be provided by a licensed enrolled PCS provider.
- A list of providers in your area who offer such services is available through either the Medicaid website or by calling the Specialty Care Resource Line toll free at 1-877-455-9955 or TTY at 1-877-544-9544.
- To obtain the information from the website, go to www.medicaid.la.gov, click on Locate a Provider, click on provider group Personal Care Services, PCS-EPSDT and then the region or parish where the beneficiary resides.



How do I find a PCS provider? – Medicaid Managed Care Program

- Personal Care Services must be prior authorized by the beneficiary's Managed Care Organization. Service must be provided by a licensed enrolled PCS provider.
- A list of providers in your area who offer such services is available via the online provider directory at www.myplan.healthy.la.gov, by calling the Member Services Line at each Managed Care Organization to locate a provider in their network, or by accessing the MCO's website to identify providers contracted with the beneficiary's MCO. (Refer to *Medicaid Managed Care Appendix B* for Member Services Lines and links to websites)



What if a PCS provider is not available? – Legacy Medicaid

- If you cannot find a PCS provider in your area that is willing to submit a request for prior authorization, call the LDH program staff line at 1-888-758-2220 and tell them that you cannot find a provider. **If a provider cannot be located, LDH must take all reasonable steps to find a willing and able provider within ten days.**



What if a PCS provider is not available?

– Medicaid Managed Care Program

- If you cannot find a PCS provider from the Medicaid Managed Care Program website, or the provider directory, which is willing to submit a prior authorization request call the MCO's member service line which operates from 7am-7pm, M-F, for assistance.
- The Support Coordinator must fax the Referral to Medicaid Managed Care Case Management (MMCCM) form (*Medicaid Managed Care Appendix Q*) within 3 days of the date of service request to get assistance from the MCO with locating a provider.
- **If the MCO is unable to locate a willing provider within 10 days of the Referral to MMCCM, the SC should submit a referral to the LDH Medicaid PAL using *Medicaid Managed Care Appendix S-1, S-2, and S-3.***



What if a PCS provider cannot find staff? – Legacy Medicaid

- The support coordinator must notify the Medicaid Prior Authorization (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.



What if a PCS provider cannot find staff? – Medicaid Managed Care Program

- If the provider is unable to find staff after services have been approved call the MCO's member services line which operates from 7am-7pm, M-F , for assistance. This shall be documented in the case record.
- Support Coordinators should fax the Referral to Medicaid Managed Care Case Management form (*Medicaid Managed Care Appendix Q*) to the MCO to request assistance.



Extended Home Health Services

- What is Extended Home Health (EHH)?
 - Skilled nursing services for medically necessary home care that requires at least three hours of nursing care per day.
 - A physician must order this service, and Extended Home Health Services must also be prior authorized.
 - Available for Medicaid beneficiaries aged 0 through 20.
- Home Health Services for children and youth are not limited in terms of frequency or duration but are based on medical need.



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? – Legacy Medicaid

- If you have contacted all of the providers on the current EHH provider list, and cannot find a Home Health Services provider in your area that is willing to submit an application for the services the beneficiary needs, call the LDH program staff line at 1-888-758-2220 and tell them you cannot find a provider.
- The LDH program staff line's hours of operation are 8:00a.m.- 4:30p.m. with a voice mail message system for overflow and after hour calls.
- **LDH will take all reasonable and necessary steps to obtain a provider who is willing to submit a prior authorization request within ten days.**



What if a Home Health provider is not available? – Medicaid Managed Care Program

- If you have contacted all of the providers on the current EHH provider list, and cannot find a Home Health Services provider in your area that is willing to submit an application for the services the beneficiary needs, call the MCO's member service line which operates from 7am-7pm, M-F, for assistance.
- The Support Coordinator must fax the Referral to Medicaid Managed Care Case Management (MMCCM) form (Medicaid Managed Care Appendix Q) within 3 days of the date of service request to get assistance from the MCO with locating a provider.
- If the MCO is unable to locate a willing provider within 10 days of the Referral to MMCCM, the SC should submit a referral to the LDH Medicaid PAL using Medicaid Managed Care Appendix S-1, S-2, and S-3. LDH will forward the referral to the MCO requesting notification upon resolution.



What if a Home Health provider cannot find staff? – Legacy Medicaid

- If the provider is unable to find staff after the service has been approved, the support coordinator must notify the Medicaid Prior Authorization Liaison (PAL) using the Referral to Medicaid PAL form (*Appendix S*). This shall be documented in the case record. Medicaid PAL contact info is on slide 153.
- The support coordinator should call the LDH program staff line at 1-888-758-2220.
- The support coordinator should assist the family in finding another provider agency with available staff from the LDH website list of providers. If a provider cannot be located, LDH must take all reasonable steps to find a willing and able provider within ten days.



What if a Home Health provider cannot find staff? –Medicaid Managed Care

- If the provider is unable to find staff after services have been approved call the MCO's member services line which operates from 7am-7pm, M-F , for assistance. This shall be documented in the case record.
- Support Coordinators should fax the Referral to Medicaid Managed Care Case Management form (Medicaid Managed Care Appendix Q) to the MCO to request assistance.
- The support coordinator should assist the family in finding another provider agency with available staff from the MCO's list of providers. If a provider cannot be located, the MCO must take all reasonable steps to find a willing and able provider within ten days. If the MCO is unable to locate a willing provider within 10 days of the referral, the Support Coordinator should submit a referral to the Medicaid PAL. LDH will forward the referral to the MCO requesting notification upon resolution.



Other Home Health Services

- Intermittent Nursing
 - Needs for less than three hours of nursing care per day can be prescribed by a doctor and obtained without prior authorization for beneficiaries aged 0 through 20, with the exception of multiple daily visits.
 - These services must still be ordered by a physician and provided by a Home Health services provider.
- Home Health Services providers can also provide in-home speech, occupational or physical therapy if this is medically necessary. Therapy services must be prior authorized.
- 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.

Pediatric Day Health Care (PDHC)

- Serves medically fragile individuals under the age of 21, including technology dependent children, who require close supervision.
- PDHC facilities offer an alternative health care choice or supplement to receiving in-home nursing care.
- PDHC may be provided up to seven days per week and up to 12 hours per day as documented by the beneficiary's Plan of Care.
- Care and services to be provided shall include but shall not be limited to: (a) Nursing care, including but not limited to tracheotomy and suctioning care, medication management, and IV therapy, and gastrostomy care. (b) Respiratory care. (c) Physical, speech, and occupational therapies. (d) Assistance with activities of daily living. (e) Transportation to and from the PDHC facility.
- 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, and Audiology Services

- For Medicaid to cover these services at school (ages 3 to 21), they must be part of the child's Individualized Education Plan (IEP) or Individualized Family Support Plan (IFSP).
- For Medicaid to cover these services through an outpatient facility, in a rehabilitation center, or home health, they must be ordered by a physician. They do not need to be part of the IEP but must be prior-authorized by Medicaid.



Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services

- The Support Coordinator is to explain to the beneficiary/family that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP.
- The Support Coordinator is to ask the beneficiary/family if they want to request any medically necessary therapies now or if they want to receive therapies on the IEP during the school's summer break.
- The Support Coordinator helps the family to determine the setting in which the child will receive the greatest benefit, and also helps the family by making the appropriate referral and coordinating the days and times of this service with other services the beneficiary is receiving and monitoring the delivery of the services.

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** for Legacy Medicaid services or the beneficiary's Medicaid Managed Care Case Manager for Medicaid Managed Care Program services.
- 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 or the MCO will take all reasonable and necessary steps to obtain a provider who is willing to submit a prior authorization request within ten days.**



Medical Equipment and Supplies

- Beneficiaries are entitled to any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions.
- This includes lifts and other devices to help the family deal with a child's medical condition. It also includes some necessary dietary or nutritional assistance.
- Medical Equipment and Supplies must be prescribed by a physician and prior authorized.



Medical Equipment and Supplies

- Includes 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 or MCO prior authorization unit may approve **less expensive items** that it believes will meet a beneficiary's needs. If so, the notice of denial should identify the items.
 - The beneficiary can accept the less costly item and still appeal the denial of the item originally requested; however, they must not dispose of, destroy, or damage (beyond normal wear and tear) the less expensive item while the appeal is pending.
 - You should consult with the beneficiary and the provider to see if the less costly item identified will work, and help the beneficiary decide whether to appeal for the item originally requested.
 - The support coordinator must explain appeal rights to the family and assist in the appeal if the beneficiary wants that help.



Other Medicaid Services Not Listed

- Refer to *Appendix F* for an expanded list of available services.
- To ask about other available services, contact the Specialty Care Resource Line at 1-877-455-9955 or TTY 1-877-544-9544 or the beneficiary's Managed Care Organization Member Services line or the beneficiary's Medicaid Managed Care Case Manager.



Non-Medicaid Services

- Many non-Medicaid sources of supports and services are available, such as:
 - OCDD Human Service Districts and Authorities
 - Flexible Family Funds (Cash Subsidy)
 - Individual and Family Supports
 - Human Services District / Authorities Support Coordination
 - Refer to the EPSDT Targeted Population Support Coordination Training Handbook pages 22-23 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 25-26 and Appendix I.
- Services Available through School Systems including Early Childhood Education programs.
 - Each school system in Louisiana has a Child Search Coordinator who can arrange for evaluations of children to determine whether or not the child has a disability and requires special educational services.
 - Refer to the EPSDT Targeted Population Support Coordination Training Handbook pages 26-28.
- Other community services



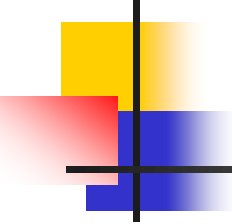
Home and Community Based Waivers for People with Developmental Disabilities

- Most children currently receiving EPSDT Support Coordination services are on the Developmental Disabilities Request for Services Registry (DD RFSR) for the following Developmental Disabilities Medicaid Waiver programs:
 - New Opportunities Waiver
 - Supports Waiver
 - Residential Options Waiver, and
 - Children's Choice Waiver.



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 \$17,500 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. Additionally, once your child turns age 21, and continues to meet the eligibility criteria, your child would transfer to an appropriate adult Waiver.



What Happens at Age 21?

- The beneficiary becomes ineligible for some services at age 21, including support coordination, EPSDT Personal Care Services, Extended Home Health Services, incontinence supplies, and other items or services that are not part of Medicaid services for adults. Inform the beneficiary of the change in Medicaid services and encourage them to obtain exams, glasses, DME, etc. prior to aging out.
- The support coordinator should be aware of available services and make arrangements to transition the beneficiary to receive all services he or she may need in order to continue to live in the most integrated setting that is appropriate for him or her.
- The support coordinator should begin making arrangements for transition at least 6 months prior to the beneficiary's 21st birthday.
- Provider agencies may need to be changed if the current provider only services children.



What Happens at Age 21?

Available services may include:

- OCDD services, including (in addition to those listed previously) extended family living, supported independent living, and vocational and rehabilitative services.
- Long Term-Personal Care Services (LT-PCS) through Medicaid. Beneficiaries who are receiving EPSDT-PCS will be contacted by Conduent regarding LT-PCS. The support coordinator should inform the family to expect notification via phone or mail. Call 1-877-456-1146 (TDD 1-855-296-0226) for additional information.
- OAAS - Community Choices Waiver and Adult Day Health Care Waiver - if they have a Statement of Denial from OCDD such as those receiving Special Needs Support Coordination. Call 1-877-456-1146 to request to be placed on the Request for Services Registry.
- Louisiana Rehabilitation Service may provide assistance with services needed to pursue short or long-term employment goals including higher education.



Support Coordination



How to Access EPSDT Support Coordination

- Individuals on the Developmental Disabilities Request for Services Registry (DD RFSR) are notified of the availability of Support Coordination (SC).
- 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 EPSDT Support Coordination services at any time.
- To access services, individuals on the DD RFSR, for whom the service is determined medically necessary, or with documentation from Medicaid to substantiate that the EPSDT beneficiary meets the definition of special needs (Appendix P) may call SRI at 1-800-364-7828 and request Support Coordination for EPSDT.
- If an individual is not yet on the DD RFSR they can contact their Local Governing Entity (refer to Appendix G).
- If they receive a Statement of Denial from OCDD they may still be eligible for EPSDT SC if they meet the definition of Special Needs (refer to Appendix P).



Medicaid Eligibility Verification

After linkage is made:

- Validate Medicaid Eligibility through MEVS/REVS or e-MEVS. Obtain information on their Medicaid coverage.
- At the beginning of every month continue to validate Medicaid Eligibility through MEVS/REVS or e-MEVS. If the beneficiary becomes ineligible for Medicaid, they are no longer eligible for Support Coordination and closure procedures shall be followed (as identified in the EPSDT Targeted Population Support Coordination Training Handbook pages 106-107).



Intake

- Contact the individual within 3 business days of linkage.
- At that time, an appointment should be set up to discuss what support coordination is and how it can benefit the individual.
- The individual should be asked about formal information documents they may have or can obtain prior to the CPOC assessment, including the current IEP, current PDHC Plan of Care, and/or current EHH Plan of Care.



Intake

- Determine if the individual is a competent major.
 - If they are a competent major and there is no record of interdiction and the individual is able to express his/her preferences, the Support Coordinator must speak directly to the individual until an Authorized Representative Form (*Appendix U*) or a supported decision-making agreement is on file, should they choose to have an Authorized Representative or a support network to help with decision-making.
 - If they are a competent major and there is no record of interdiction and the individual is unable to express his/her preferences, the Support Coordinator must document this in the CPOC and obtain an Authorized Representative Form (*Appendix U*) or a supported decision-making agreement to allow a caregiver to be the EPSDT contact and sign on behalf of the individual.



At the Face-to-Face Visit

- Complete a face-to-face visit within 10 calendar days of linkage.
- The Support Coordinator must explain the following to the individual:
 - Explanation and review of the Medicaid Services Chart (Appendix B)
 - Services Available to Medicaid Eligible Children Under Age 21 (*Appendix F*)
 - Appeal Process (*Appendix L*)
 - Complaint Process for filing a report against support coordinators and/or Legacy Medicaid Providers (*Appendix M*)
 - Discuss with Chisholm Class Members their right to choose between Legacy Medicaid and the Medicaid Managed Care Program for their physical health services (*Medicaid Managed Care Appendix H*)
 - Complaint Process for filing a report against Managed Care Organizations or Medicaid Managed Care Program providers (*MMC Appendix I*)
 - Support Coordination Responsibilities and Participant Rights and Responsibilities (*Appendix K*)
 - HIPAA & Confidentiality notification
 - Referral to EPSDT Screening provider (if requested)
 - Availability of formal and non-formal services



At the Face-to-Face Visit

- Determine if the individual accepts Support Coordination and agrees with the requirements of the face-to-face visits.
- The individual is often overwhelmed with everything they are being told in this first meeting. Do not expect the individual to remember everything, even if you are providing information in writing.

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



Assessment

- Must begin within 7 calendar days of linkage.
- Assessment is the process of gathering and integrating formal and informal information relevant to the development of a person centered CPOC.
- Formal information includes medical, psychological, pharmaceutical, social, educational information, and information from OCDD.
- Informal information includes information gathered in discussions with the family and beneficiary and may also include information gathered from talking to friends and extended family.
- The SC may need to assist the individual in arranging professional evaluations and appointments including activating examination/diagnosis/treatment loop such as EPSDT Screening exams and follow-up evaluations.



Assessment

- The SC is to obtain the current IEP and any other assessments by professionals (EPSDT-PCS Form 90, Home Health Plan of Care, PDHC plan of care, LRS and Special Education Evaluations, behavior plans, psychological evaluations, etc.) that are required to obtain CPOC approval.
- The SC is to contact OCDD, schools, Pupil Appraisal and health care professionals for necessary records and ask the individual about documents they may have or can obtain from their school, and follow up on requests for records.
- The Case Management Choice and Release of Information Form (FOC) must be used to obtain all plans, evaluations, and assessments that OCDD has developed or used in connection with its determination that the individual is eligible for services through the developmental disability services system. (*Appendix N shows a sample of the form you will receive upon linkage.*)



Comprehensive Plan of Care (CPOC)

- The Comprehensive Plan of Care (CPOC) is the Support Coordinator's blueprint for assisting the individual.
- The CPOC is developed through a person-centered planning process and is based on the comprehensive information gathered during the assessment process.
- The CPOC is based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the individual.



Comprehensive Plan of Care (CPOC)

- The CPOC must be completed in a face-to-face in home meeting with the beneficiary's support team. The support team is made up of the beneficiary, legal guardian, Support Coordinator, and other people chosen by the beneficiary that know them best such as family, friends or other support systems, or direct service providers. All references to the individual include the role of the individual's representative.
- **Everyone** present at the meeting must **sign** the CPOC Participants Signature Page in the **Planning Participants box**.



Comprehensive Plan of Care (CPOC)

- Service Needs:
 - The CPOC must include agreed upon strategies to achieve or maintain the personal outcomes using appropriate natural, community supports, non-formal, and formal paid services.
 - Use all assessment and intake information to identify the individual's needs and identify those additional services that will meet their unmet needs.
 - Assist the individual to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes.
 - Document services the individual is currently receiving.
 - Must include timelines in which the personal outcomes can be met or at least reviewed (minimum requirement is quarterly).



Comprehensive Plan of Care (CPOC)

- Do not wait for the individual to request a service. **If you see a need for a service, inform the individual and document their response.**
- If the individual may need additional services, but it is not clear, suggest appropriate evaluations to determine whether there is a need.
- One of the primary responsibilities of the Support Coordinator is to follow through with requests for services.



Comprehensive Plan of Care (CPOC)

- 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
- Also available for your use is a PCS vs. Home Health Chart (*Appendix E*) that will assist in identifying the need for these services. Please 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 not required to be in the home while services are being provided to children.



Comprehensive Plan of Care (CPOC)

- The CPOC is to be completed electronically in Louisiana Support Coordinator Information System (LSCIS).
- The CPOC is designed to briefly summarize important information so that it can be reviewed and considered in evaluating the need for proposed services and supports.
- Information relevant and applicable to justifying services requested by the individual must be provided.
- Information critical to the individual's health and safety should be documented in the CPOC.
- The CPOC should always emphasize the individual's personal outcomes. The goal is to provide support and services in a person focused, cost effective and accountable manner.



Comprehensive Plan of Care (CPOC)

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

The content of the LSCIS CPOC includes:

- Section I - Contact Information / Demographic Information
- Section II - Medical/Social/Family History
- Section III - CPOC Service Needs and Supports
- Section IV - CPOC Participants
- Section V - CPOC Approval
- Section VII - Typical Weekly Schedule (paper form)



Comprehensive Plan of Care (CPOC)

Section 1 – Contact Information / Demographic Information

- This initial portion of the CPOC is self-explanatory and requires the SC to develop current contact information on the individual, including name, mailing and physical address, good contact numbers, SSN, Medicaid ID, ICD-10, etc. Nothing should be left blank.
- Include information about the legal guardian and relationship.
- If the individual is a competent major document if they can direct their own care.

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 individual's life (past and current situations), their health, and psychological and/or behavioral concerns. Any pertinent information about the individual that can be provided by the family or gathered from formal information documents should be documented.
- It is the Support Coordinator's job to look at and respond to the needs of the beneficiary; however, often the family's needs have a direct impact on the beneficiary's needs.
- If any information is unknown, state that it's unknown.



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 beneficiary is eligible for screenings, which can help to determine his/her health needs. It is the Support Coordinator's responsibility to help the beneficiary access those screening services.
- If formal information documents, interviews with caretakers, information in the case record, or SC observations identify the need for Psychological and/or Behavioral Services it must be addressed on the CPOC. Any beneficiary with psychological or behavioral concerns (victim of child abuse, loss of parent or close family member, school suspension or expulsion, recent catastrophic injury, acting withdrawn, etc.) should be offered services.
- **Always document the offer of services and response received.**



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

- **Past – Pertinent historical information.**
 - Prenatal Health
 - Nature and cause of disability
 - Age of diagnosis and made by whom
 - Any early intervention services received
 - 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 - Describe current living situation and natural supports.**
 - Names and ages of all household members
 - Family situation and social support network
 - Address mom and dad and if they provide any natural or financial support
 - Relevant social, environmental and health factors that impact the beneficiary
 - Access to transportation and community
 - Source of household income



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

- **Medical Diagnoses - A brief narrative description of the person's health history, current medical condition, including medical diagnoses, hospitalizations and continuing health concerns and medical needs should be included.**
 - List all diagnoses and what *current* formal documentation you have to support their qualifying diagnosis or diagnoses.
 - If any diagnosis is "parent states" and you don't have documentation to back it up address what you're doing to obtain documentation. If no documentation exists address if they want a referral for an evaluation.
 - List all doctor's names, their specialty, how often they see them, and last visit/next visit identifying if they overdue for a visit.
 - List all medications and what they are prescribed for.



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

■ Medical Diagnoses

- 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?
- Vision
- Hearing
- Communication
- Ambulation
- 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? Be specific.
- 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

- Dates of formal information documents used in the development of the CPOC are to be listed. At least one current formal information document is required in the development of an annual CPOC. Current means that the formal information document was less than a year old at the time of the plan of care meeting.



Comprehensive Plan of Care (CPOC)

Section 2 – Medical/Social/Family History

■ Evaluation/Documentation

- Must have the following documents on file:
 - A current formal information document that was less than a year old at time of the CPOC meeting.
 - Current IEP if receiving Special Education
 - Current EHH Plan of Care if receiving Extended Home Health
 - Current PDHC Plan of Care if receiving Pediatric Day Healthcare
 - Current SOA from OCDD 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

- This section of the CPOC identifies service needs including the service strategy and a description, how the need was determined, if the individual requests to receive the identified need and any reasons why not, the primary goal, who is providing the support, if the service requires PA tracking, and the amount of service approved.
- Identify all services the individual is currently receiving, both Medicaid and non-Medicaid, and those services that are requested, clearly identifying each and the amounts approved.



Comprehensive Plan of Care (CPOC)

Section 3 - CPOC Service Needs and Supports

- Make sure to select the appropriate service from the Service Strategy picklist.
- List every service need separately.
- Check the appropriate box of who will be providing/funding the service need – Medicaid, School, Community, Family (private insurance or out of pocket), or OCDD.
- Assure and document at the time of the CPOC meeting the individual understands that services and goals may be added whenever a request is made, if they chose not to access a service when the need is first identified.



Comprehensive Plan of Care (CPOC)

Section 3 - CPOC Service Needs and Supports - Service Strategy picklist

- **Personal Care Services**
- **Home Health Services** – Extended Home Health, intermittent nursing, in-home ST/OT/PT
- **Medical Equipment and Supplies** - one time DMEs like wheelchairs, hospital beds or weighted blankets and ongoing DMEs like formula, trach supplies, or g-tube supplies.
- **OT, Physical Therapy, Speech Therapy** – community therapies
- **Specialized Behavioral Health** - psychiatrist, behavioral medications, social workers, counseling, Mental Health Rehabilitation (Psychosocial Rehab, Community Psychiatric Support and Treatment, Crisis Intervention, Crisis Stabilization)
- **Dental Services**
- **Eyeglasses** – eyeglasses or contact lenses
- **Transportation** – NEMT or gas reimbursement program
- **Diapers**
- **School** – Therapies (OT, PT, ST), Assistive Technology (AT), Social Worker, Nursing
- **Vocational**
- **Employment**
- **Transition** (if the beneficiary will be twenty and half years old that CPOC year)
- **Pediatric Day Health Care**
- **Applied Behavioral Analysis**
- **Other**
- **Home Modifications**
- **Community Services**
- **Redetermination** (if the SOA expires that CPOC year)
- **OCDD Services** – family flexible fund, family support, respite
- **CSoC** - Wraparound, Peer Support, Parent Support, Independent Living Skill-Building Services, Short-term Respite
- **Evaluation** – any needed evaluations (psychological, CDE, etc.)
- **EPSDT Screening Exam**
- **Hearing Aids**
- **Hospice Services**
- **Physician/Professional** – needed referrals for doctors, anyone they are overdue for a visit with.



Comprehensive Plan of Care (CPOC)

■ Section 3 - CPOC Service Needs and Supports

- If a service need is not being requested now you have three options to explain why:
 - **Carried Over – Resolved:** The service need is no longer an identified need. Will fall off the CPOC after CPOC approval.
 - **Family Does Not Want:** The need for the service has been identified but the individual declines the service.
 - **Other – Explain Next Page:** The need for the service has been identified but it is placed on hold until a later time. The individual will request the service need in the future.
- Always explain your reason in Section 4 – Additional Information.

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 #: 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](#)

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

- The beneficiary and the legal guardian must be present for the CPOC meeting.
- Planning Participants - **Everyone** present at the meeting must **sign** in the **Planning Participants box** and indicate their Title and Agency Name as applicable. This includes the beneficiary, the legal guardian, the Support Coordinator.
- The beneficiary and/or legal guardian/authorized representative must sign and date the completed CPOC.
- The support coordinator present at the meeting must sign the CPOC.
- The SC supervisor must 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 provided to address information regarding service needs and supports. The names of all service providers and any additional strategy information are to be placed in this section.
- If on a waitlist 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:
 - If the PA is *issued* monthly
 - If the EHH nurse is the person ordering and tracking medical supplies
 - If the beneficiary is on a waitlist for the service
 - If the MCO does not require a PA for the service
 - 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*).
 - *Refer to page 56-58 of the Handbook for more detailed information.*



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*) and Medicaid EPSDT Services (Services Available to Medicaid Eligible Children Under 21 - *Appendix F*)
 - Information on EPSDT Screening services
- Identify how often the goals and support strategies will be reviewed. The CPOC must be reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

LSCIS CPOC Section 4 – Additional Information / CPOC Participants

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 all of the listed evaluations/documentation used to develop the CPOC, service logs, and quarterly reviews for identified needs and the status of requested services prior to signing and submitting the CPOC to SRI.
- The entire CPOC must be reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.
- The Support Coordinator must submit the *approvable* CPOC to SRI no later than 35 calendar 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 to SRI with the required documents for all Special Needs SC cases.
- The CPOC may be randomly selected for monitoring when the SC supervisor submits it to SRI for review. The Monitoring Checklist (*Appendix X-2*) and required documents must be received by SRI within two working days.
- 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.



Comprehensive Plan of Care (CPOC)

Section 5 – CPOC Approval Information

- The Support Coordinator is responsible for requesting and coordinating all services identified in the CPOC immediately upon completion of the CPOC (date the recipient or parent/guardian signed the approval page) and prior to approval from SRI.
- Approval of Medicaid state plan services is through the PA unit, therefore, the Support Coordinator should not await SRI approval of the CPOC before making referrals for necessary services.
- Again, the CPOC does not control the services. This process only controls the payment to Support Coordination Agencies.

LSCIS CPOC Section 5 – CPOC Approval Information

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



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 beneficiary wishes to change any of the times for established services, the support coordinator shall give the revised schedule to all appropriate providers informing them of the time changes.
- 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 individual a Choice of Providers (unless they are already satisfied with a provider). Information on accessing provider lists is found on slides 24-30.
 - Assist the individual in contacting prospective providers and finding out if they are willing to submit prior authorization requests.
 - If none of the Legacy Medicaid providers are able to provide the requested service, call the LDH Program Staff Line at 1-888-758-2220 to report the difficulty. For services accessed through an MCO refer to slides 201-202.



Coordination of Services

- Support Coordinators should:
 - Have the individual list the provider they choose and sign the Choice of Provider Form for EPSDT Medicaid Providers (*Appendix Z*).
 - Make referrals to the appropriate providers/MMCCM (*Appendix Q, MMC Appendix Q*).
 - Give the individual the medical information forms that are required for the specific service. (Many forms can be found in *Appendix R-1*).
 - Assist with scheduling the doctor appointment, transportation, etc., as needed.
 - Assist the individual/provider in gathering the appropriate documentation needed to support the request.



Coordination of Services

- Support Coordinators should:
 - For Legacy Medicaid Services, notify the Medicaid PAL if the EHH, PCS, PT, ST or OT provider is unable to find staff after the services have been approved.
 - For Medicaid Managed Care enrollees, call the Member Services Line at their Managed Care Organization.



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 as a Service Need on the CPOC Service Needs and Supports in LSCIS and check the “Medicaid” and “Requires PA tracked by SC” boxes for that Service Strategy. Then follow the prompts on the Tracking Required Action Report beginning with opening an **EPSDT Prior Authorization Tracking Log.**



Coordination of Services

- Legacy Medicaid Services

- Complete the Referral to Provider form (Appendix Q) and send it to the chosen provider.
- 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).

- Medicaid Managed Care Services

- Complete the Referral to MMCCM form (Medicaid Managed Care Appendix Q) and send it to the Single Point of Contact at the beneficiary's MCO (MMC Appendix A).
- Referrals to MMCCM 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. (Refer to MMC Appendix T-2).



Coordination of Services

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



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 beneficiary 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 beneficiary 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/MMCCM if you have not received a copy of the Request for Prior Authorization Form.
- Allows you to know at a glance when, and if, services were/were not approved



EPSDT Prior Authorization Tracking Log

- The PA Tracking Log:
 - Allows you to document information about the PA decision notice.
 - Allows you to document that you offered/provided appeal assistance to the beneficiary and provided the Appeals brochure.
 - Serves as a reminder of when the notice should be sent to the provider/MMCCM to renew services.



EPSDT Prior Authorization Tracking Log

- A separate tracking log is completed for each service that requires prior authorization.
- A new **Renewal** tracking log is used for each PA cycle after the reminder notice for renewals is sent to the provider/MMCCM. The date the reminder notice is sent is the date of referral for a new tracking log. Keep the date of service request the same as the previous tracking log.
- A new **Change in Service** tracking log is used for changes in existing services (i.e. additional hours of service requested, change in providers). Keep the date of service request the same as the previous tracking log.



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 Service Request and Date of COP (Choice of Provider)
 - Provider
 - Date of Referral to
 - Required Provider/MMCCM Contacts
 - Referral to PAL (if required)
 - PA Approval and Dates



Coordination of Services

- Legacy Medicaid 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 beneficiary 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 beneficiary about their right to change providers.



Coordination of Services

- Medicaid Managed Care Services:
 - Within 15 calendar days of Referral to MMCCM, the SC must contact the MMCCM to seek assistance with finding a provider if one has not been chosen.
 - Within 35 calendar days of Referral to MMCCM, the SC must contact the MMCCM to seek assistance with finding a provider if one has not been chosen.
 - Within 15 calendar days of Referral to MMCCM, the SC must contact the MMCCM or the provider to confirm that the provider is working on the request and whether any assistance with gathering information is needed.
 - If the SC does not receive a copy of the Request for Prior Authorization form within 35 calendar days of the referral to MMCCM, contact should be made with the MMCCM or the provider to ensure the request has been sent to the MCO.
 - Note: Before the COP, the required contacts must be made with the MMCCM. Following the COP, the required Provider/MMCCM contacts can be made with either the MMCCM or the Provider or both.
 - Refer to *Medicaid Managed Care Appendix T-2*.



Coordination of Services

- Medicaid Managed Care Services:
 - If after 35 calendar days the provider has not submitted the PA packet to the MCO, the Support Coordinator should alert the MCO. A 35 Day Medicaid PAL Referral is not required.
 - If you have not received a decision within 60 calendar days from the Choice of Provider date, send a Referral to the Medicaid PAL (*MMC Appendix S-1, S-2, S-3*)
 - If the PA notice is not received from the provider, the PAL or MCO can give you the PA information over the phone. Do NOT take verbal information from providers.

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: 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 Beneficiary, Provider, Medicaid Managed Care Case Manager, PAL, SRI, and LDH Program Staff Line must be documented including monthly and as needed contact with the individual 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



The PAL unit was established to facilitate the PA approval process for Medicaid beneficiaries under age 21 who are on the Developmental Disabilities Request for Services Registry.



Prior Authorization Liaison



- The Chisholm v. 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
 - Missing or incorrect diagnosis codes
 - Incorrect procedure codes
 - Prescription not signed by the doctor



Prior Authorization Liaison



- The PAL will attempt to resolve the problem.
- Within 24 hours of the PAL receiving the request, the PAL makes the initial contact by phone or fax to the provider, beneficiary, and support coordinator.



Prior Authorization Liaison



- If the issue is not resolved after 10 days of initial contact with the provider, a Notice of Insufficient Documentation is sent to the provider, beneficiary and support coordinator advising them of the specific documentation needed.
- The beneficiary has 30 calendar days to either supply the needed documentation, or notify the PAL with the appointment date that has been made with the health professional to obtain it.



Prior Authorization Liaison



■ Support Coordinator Role

- Communicate promptly with the PAL to facilitate requests for information.
- Communicate with the individual and provider and provide assistance in assembling documentary support on prior authorization requests.
- Follow up so that a PA decision is received, instead of having the service denied due to a lack of information.
- Track status of requests:
 - Advise PAL of providers not actively developing requests.
 - Inform beneficiaries of right to choose another provider.
 - Assist beneficiaries in locating another provider.



Prior Authorization Liaison



- Support Coordinator Role (continued)
 - If a “Notice of Insufficient Documentation” is received, assist the beneficiary in obtaining documentation. If you are not sure enough additional information is available, help the beneficiary schedule an appointment with a health professional and return the second page of the Notice filled in with the date of the appointment to the PAL.
 - When a SC closes a PA tracking log that had a PAL Referral that was sent to LDH, the SC should notify LDH of the closure date and reason. This allows LDH staff to focus on the active PAL Referrals.



Prior Authorization Liaison



- **Contacts**

- **Gainwell Technologies PAL**

- Monica Anderson
 - 225-216-3224
 - Fax: 225-216-6478
 - Gainwell Technologies
 - Prior Authorization Liaison
 - P. O. Box 14919
 - Baton Rouge, LA 70898-4919

- **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 Gainwell Technologies PAL to return calls to her.

Prior Authorization Liaison MCOs

■ Aetna

DeAndralee Emery

EmeryD@aetna.com

Phone: 959-299-6412

Fax: 844-227-9205

Sherri Chairs

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Phone: 959-299-6581

Fax: 844-227-9205

■ UnitedHealthcare

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Fax: 866-311-3754

Kimberly Auger, RN

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CHARTICE FEASTER, BSN RN

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Phone: 225-201-8583

Fax: 877-401-8175

*See Medicaid Managed Care
Appendix A*



Prior Authorization Liaison



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

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, beneficiary, and support coordinator within 24 hours.
- The support coordinator is to assist in obtaining the additional information. This will not supplant the responsibilities of the provider.
- The support coordinator will receive a copy of all notices (i.e. approved, denied, reduction in services and request for additional information) regarding the requested service.



Coordination of Services

- **Follow-up shall be made with the beneficiary 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 beneficiary is not satisfied, the support coordinator shall follow-up with the provider. If it cannot be resolved, the support coordinator will alert the PAL using the Referral to the PAL Form – *Appendix S* for Legacy Medicaid services or alert the MCO using the Referral to MMCCM Form – *Appendix Q*. If the MCO cannot resolve the issue, alert the PAL using Referral to PAL form - *MMC Appendix S*.
- **You must report to BHSF/SRI all services where a decision was not made within 60 days from the completion of the CPOC or from the COP 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 actually put in place using the legally accepted correction procedure. The schedule change does not have to be sent to SRI at this time.
- The Support Coordinator shall give the revised schedule to all appropriate providers informing them of the time changes to facilitate the 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.

- For Legacy Medicaid services, the Support Coordinator must send a reminder letter (Referral to Provider form - *Appendix Q*) to the provider no less than 45 or more than 60 calendar days prior to the expiration of the prior authorization.
- For Medicaid Managed Care services, the SC must send a reminder letter (Referral to Medicaid Managed Care Case Management - *Medicaid Managed Care Appendix Q*) to the Medicaid Managed Care Case Manager no less than 20 days or more than 60 days prior to the expiration of the prior authorization.

Coordination of Services - Appeals/Reduction in Service Requests

- The support coordinator must inform the beneficiary 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 beneficiaries 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.

*For information on internal Medicaid Managed Care Program appeals, refer to Medicaid Managed Care Appendix F. 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 individual if they need/want assistance with filing the appeal.
- The support coordinator must assist with an appeal if assistance is wanted by the beneficiary. 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 beneficiary 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 beneficiary 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 beneficiaries 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.
 - 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.
 - Determine service start date after the PA is received.



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. The service needs section of the Quarterly Review should document if services are received and if the beneficiary/family is satisfied with their services and their providers.
 - Additional services requested
 - Scheduling issues (update the Typical Weekly Schedule)
 - Completion of the EPSDT CPOC Quarterly Review/Checklist and Progress Summary located in LSCIS.

Note: The face-to-face quarterly visit does not have to be completed in the beneficiary's home. The original signature page must be kept in the case record. Refer to pages 88-89 for instructions on completing the Quarterly Review.

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
		///
		///
		///
		///

Edit



Follow-up Requirements - Forms

- Changes to the CPOC which includes the Typical Weekly Schedule should be made:
 - To reflect the changes if prior approval of a requested service is denied (and not successfully challenged through a fair hearing request or other advocacy).
 - When strategies are needed to deal with problems with services or providers. Resolving problems and overcoming barriers to beneficiaries' receiving services is a key goal of the CPOC process.
 - When significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment. The CPOC should be updated and goals and objectives should be added and/or revised according to the most recent information available.



Follow-up Requirements - Forms

- Beneficiary Complaint Form (*Appendix M*) shall be used as needed by the beneficiary to make a complaint against a direct service provider/worker or a support coordinator.
- The Healthy Louisiana Line at 1-855-229-6848 shall be used as needed by the beneficiary to make a complaint against a MCO or complaints can be e-mailed to healthy@la.gov. Refer to Medicaid Managed Care Complaints - *MMC Appendix H*.
- Service delivery issues use the Referral to PAL - *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 beneficiaries 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 beneficiaries 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 beneficiaries and the services for the following:
 - Beneficiaries whose request for services did not result in a PA being issued within 60 days.
 - Beneficiaries with gaps in the authorization period.
 - Beneficiaries 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 Beneficiary 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 beneficiary/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 beneficiaries 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, and
 - prior to being assigned an EPSDT caseload.
 - All support coordinators and trainees must complete EPSDT training each year as part of their 20 hours of annual training. The agency's Designated Trainer and Supervisors will be responsible for training the staff.



Requirements for Support Coordination Agencies

- 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 as part of their 20 hours of annual training. The training may be provided by BHSF/SRI or by a trained supervisor or designated trainer within the agency.



Requirements for Support Coordination Agencies

- The agency must submit documentation of the training to the EPSDT Program Manager using the Training Log - *Appendix W-4*.
 - 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 beneficiary receives the services he/she needs.
- If at any time a provider is not actively working on behalf of the beneficiary, contact the PAL.
- Contact BHSF/SRI if you have questions or your BHSF State Office regarding policy.



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.

*Open Enrollment begins on October 15 and ends at 6 p.m. on November 30, 2021.



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.

5.20.22

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

- CCMs have a 90 day choice period from the effective date of the enrollment during which they can change MCOs for any reason.
- After 90 days, CCMs will be locked in to the MCO 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.



5 Ways Chisholm Class Members can Enroll or Dis-enroll from a Plan

1. **Mobile** - Download and use the free Healthy Louisiana mobile app on your Apple or Android device.
2. **Online** - Visit the Healthy Louisiana website anytime on your computer or laptop at www.myplan.healthy.la.gov.
3. **By phone** - Call Healthy Louisiana at 1-855-229-6848 (TTY: 1-855-526-3346). The call is free.
4. **By mail** - Mail your completed Enrollment Form in the stamped, addressed return envelope that came with the letter.
5. **By fax** - Fax your completed Enrollment Form to 1-888-858-3875. The fax is free.



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



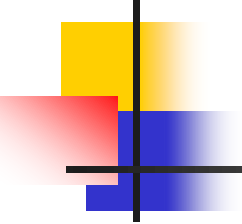
Value Added Benefits

- 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 can use the **MCO Comparison Chart** (*Medicaid Managed Care Appendix G*) to assist the CCM with their selection.
- Support Coordinators should ensure that the CCMs providers are in network. Each plan has PCPs and specialists in their provider network. You can search for providers by plan at: [MyPlan.healthy.la.gov](https://myplan.healthy.la.gov).



Selecting a Plan

- Supports Coordinators should ensure that the medications that they are currently prescribed are covered by the MCO's formulary. A common preferred drug list can be found at:

http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Pharmacy/HealthyLouisianaCommonPDL_3.1.17.pdf

It is important to check any medications not listed on the common preferred drug list with each of the plans to see if it is covered. Each plan covers different drugs and has different prior authorization and step therapy procedures.

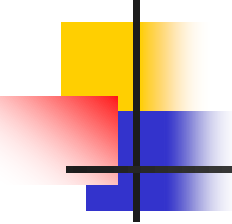
- **Aetna Better Health:**
 - <http://www.aetnabetterhealth.com/louisiana/providers/pharmacy>
- **Amerihealth Caritas:**
 - <http://www.amerihealthcaritasla.com/pharmacy/index.aspx>
- **Healthy Blue:**
 - <https://www.myhealthybluela.com/la/benefits/pharmacy-benefits.html>
- **Louisiana Healthcare Connections:**
 - <https://www.louisianahealthconnect.com/providers/pharmacy/preferred-drug-list-info.html>
- **UnitedHealthcare:**
 - <https://www.uhccommunityplan.com/la/medicaid/healthy-louisiana/lookup-tools.html#view-drug>



Selecting a Plan

- Questions for CCMs to answer:
 - Is your PCP in the health plan's provider network?
 - Are specialists you see in the health plan's network?
 - Are specialists and behavioral health providers you see in the health plan's network?
 - What special services does the health plan offer?
 - » Use the health plan comparison chart (*MMC Appendix G*)

- CCMs can call the Healthy Louisiana Line at 1-855-229-6848 (TTY: 1-855-526-3346) to enroll or go online at MyPlan.healthy.la.gov.



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 (PAL) 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 myplan.healthy.la.gov.
 - Select Choose > Find a Provider.
 - Choose between Medical and Behavioral Health Providers.
 - You can search for specific providers to see which plans they are contracted with or search for providers by Specialty (i.e. Neurology, Personal Care Attendant, etc.).
 - Call the Member Services Line at each MCO to locate a provider in their network (*Medicaid Managed Care Appendix B*)
 - Access MCO's website to identify contracted providers (*Medicaid Managed Care Appendix B*)

What if a provider is not available?



- If you cannot find a provider from the Medicaid Managed Care Program'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 of the referral, the Support Coordinator should submit a referral to the Medicaid PAL. LDH will forward the referral to the MCO requesting notification upon resolution.



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.



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 beneficiary has been advised of their right to choose another provider and the SC is beginning the process again.
 - The beneficiary 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 1-3*) 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 beneficiary 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.)

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



Communication cont'd...

- Support Coordinators should send referrals to the Medicaid Prior Authorization Liaison (*Medicaid Managed Care Appendix S 1-3*) if:
 - The beneficiary has been advised of their right to choose another provider and the SC is beginning the process again.
 - The beneficiary 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.

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

*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)
- Opting In and Disenrolling from Medicaid Managed Care Program for Physical Health Services for CCM (Medicaid Managed Care H)
- Medicaid Managed Care Complaints (Medicaid Managed Care I)
- Referral to Medicaid Managed Care Case Management (Medicaid Managed Care Q)
- Medicaid Managed Care Program Referral to PAL (Medicaid Managed Care S-1, S-2, S-3)
- Medicaid Managed Care Program EPSDT Timelines & Documentation - Beneficiary (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)



EPSDT – Targeted Population

Support Coordination Training Part 3 COVID-19



COVID-19 Pandemic

- The Louisiana Department of Health is engaged in the following priority public health actions:
 - Working with healthcare facilities with presumptive patients to identify exposed healthcare workers and make appropriate recommendations
 - Ensuring all recommended infection control precautions are implemented in the healthcare facilities until we determine that the patient is no longer infectious
 - Notifying and monitoring close contacts
 - Notifying CDC
 - Maintaining an information line.



COVID-19 Exceptions

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



COVID-19 Exceptions

- Support Coordinators will be allowed to utilize telehealth or telephone contact in place of face-to-face initial home visits, quarterly reassessments, and annual assessments for beneficiaries who are medically fragile or have medically fragile or elderly caregivers.
- Telehealth is the preferred contact method; however, if the beneficiary does not have access to Skype, FaceTime, etc., telephone contact is acceptable.
- If the Support Coordinator needs to use this exception, the SC must document the reason the exception is being used on the service log. In-person visits can still be conducted.

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



COVID-19 Exceptions

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

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



COVID-19 Exceptions

- CPOCs are allowed to be completed without beneficiary signatures until the resolution of the State or Federal declared emergency.

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



COVID-19 Exceptions

- Tracking on Prior Authorized Services will continue.
 - If a service is put on hold due to the coronavirus pandemic: SC should enter an Interim Comprehensive Plan of Care (CPOC) and mark the service need as on hold (Other – Explain Next Page). The SC must document in the Additional Information section that the service is on hold due to the pandemic.

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