OVERVIEW

The Community Choices Waiver is a Medicaid Home and Community-Based Services Waiver providing alternative services to individuals which assists them to live in the community instead of a nursing facility or institution.

This provider manual chapter specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is a combination of federal and state laws and Department of Health and Hospitals (DHH) policy which provides direction for provision of these services to eligible individuals in the State of Louisiana.

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services and proper fund disbursement. Should a conflict exist between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This manual chapter is intended to give providers of Community Choices Waiver services information necessary to fulfill their vendor contract with the State of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and department rules.

Oversight of the services offered through the Community Choices Waiver is conducted through licensure compliance and program monitoring. The DHH Bureau of Health Services Financing (BHSF) and the DHH Office of Aging and Adult Services (OAAS) are responsible for assuring provider compliance with these regulations.

Waiver services to be provided are specified in the Plan of Care which is written by the support coordinator, based on input from the planning team, and then forwarded to the OAAS or its designee for approval. The planning team is comprised of the recipient, the support coordinator, and in accordance with the recipient's preferences, members of the family/natural support system, appropriate professionals and others whom the recipient chooses. The Plan of Care contains all services and activities involving the recipient, non-waiver as well as waiver services. Recipients are to receive those waiver services included in the Plan of Care and approved by the appropriate support coordination designee or OAAS regional office (as applicable). Notification of approved services is forwarded to the provider by the support coordinator, and the contracted data management agency issues prior authorization to the providers based on the approved Plan of Care.

The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the waiver agreement with the Centers for Medicare

and Medicaid Services.