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GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Community Choices Waiver (CCW) Manual Chapter.

Abuse – The infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value. (La. R.S. 15:1503)

Abuse of Medicaid Funds – Inappropriate use of public funds by either providers or beneficiaries, including practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

Activities of Daily Living (ADL) – The functions or basic self-care tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. Activities of daily living include bathing, dressing, eating, grooming, walking, transferring and/or toileting. The extent to which a person requires assistance to perform one or more of these activities often is a level of care criterion.

Adult Day Health Care (ADHC) – A medical model adult day health care program designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community-based direct care center.

ADHC Center – Any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more adults with functional impairments who are not related to the owner or operator of such agency are provided with adult day health care services. This center type will be open and providing services at least five continuous hours in a 24-hour day for at least five days per week.

Adult Day Health Care (ADHC) Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 22-64 and have a physical disability, and meet nursing facility level of care requirements.

ADHC Waiver Request for Services Registry (RFSR) – A waiting list for the ADHC Waiver program which contains the names and dates of requests of individuals applying for an ADHC Waiver opportunity.

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Advocacy – The process of assuring that beneficiaries receive appropriate high quality supports and services and locating additional services needed by beneficiaries which are not readily available in the community.

Agency – An entity which delivers Medicaid support coordination services under an agreement with LDH/OAAS.

Allegation of non-compliance – A claim that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a beneficiary or beneficiaries. (La. R.S. 40:2009.14)

Allowable Cost – Those expenses incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied during the desk review and audit process to determine allowable costs.

Appeal – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination; a legal proceeding in which the applicant/enrollee and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer (See “Fair Hearing”).

Applicant – An individual who is requesting Medicaid Waiver services.

Assessment – One or more processes that are used to obtain information about a person, including their condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person meets nursing facility level of care and requires waiver services. The results are used to develop the Plan of Care and an Individualized Service Plan.

Beneficiary - An individual who has been certified for the CCW program. A beneficiary may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) – The Bureau within the Louisiana Department of Health is responsible for the administration of the Medicaid Program and is the administering agency for the OAAS Waiver programs.

Case Management – (See “Support Coordination”).

Centers for Medicare and Medicaid (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

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Community Choices Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 21- 64 and have a physical disability, and meet the nursing facility level of care requirements.

CCW RFSR – A waiting list for the CCW program which contains the names and dates of requests of individuals applying for a CCW opportunity.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a beneficiary or beneficiaries (La. R.S. 40:2009.14).

Continuous Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to pursue opportunities to improve services, and to correct identified problems.

Confidentiality – The process of protecting a beneficiary’s or an employee’s personal information, as required by the Health Insurance Portability and Accountability Act (HIPAA).

Corrective Action Plan – Written description of action a provider plans to take to correct identified deficiencies.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Direct Care Staff – Unlicensed staff paid to provide personal care and other direct service and support to persons qualified waiver beneficiaries to enhance their well-being, and who are involved in face-to-face direct contact with the participant.

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to beneficiaries. The EVV system will ensure that beneficiaries are receiving services authorized in their POCs, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Eligibility – The determination of whether or not a beneficiary qualifies to receive services based on meeting established criteria as set by LDH.

Enrollment – A determination made by LDH that a provider or agency meets the necessary requirements to participate as a Medicaid provider. This is also referred to as provider enrollment.

Exploitation – The illegal or improper use or management of the funds, assets or property, of a

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person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage. (La. R.S. 15:1503)

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503)

Fair Hearing – A legal proceeding in which the beneficiary and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer.

Fiscal Intermediary – The contractor, managed by Medicaid, which processes claims, issues payments to providers and agencies, handles provider inquiries and complaints, provides training for providers.

Follow-Up – A core element of service delivery to the beneficiary that includes oversight and monitoring of the provision of services, ongoing assessment and mitigation of health, behavioral and personal safety risk, and crisis management.

Formal Services – Another term for professional and paid services.

Freedom of Choice – A term used when the applicant/beneficiary is selecting the provider(s) and support coordination agency that will provide their services.

Good Cause – An acceptable reason to change agencies or providers outside of the designated circumstances and timelines.

Health Standards Section (HSS) – A section of the Louisiana Department of Health responsible for the licensure and enforcement of compliance of those health care providers licensed by the Health Standards Section.

Home and Community-Based Services Waiver – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the beneficiary's home or community as an alternative to institutional services to persons who meet nursing facility level of care. Waiver services are approved by CMS are limited to serving a specific number of individuals in accordance with the approved and available waiver opportunities.

Individualized Service Plan (ISP) – An individualized written plan of action to be completed and followed by providers to address the beneficiary's difficulties, health care needs, and services based upon their assessment. A comprehensive plan of care prepared in accordance with policies, procedures, and timelines established by Medicaid or by an LDH program office for reimbursement purposes may be substituted or used for the individual service plan for in-home

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providers.

Informal Services – Another term for non-professional and non-paid services provided by family, friends and community/social network.

Institutionalization – The placement of an individual in an inpatient facility including, but not limited to a hospital, nursing facility, or psychiatric hospital.

Internal Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to pursue opportunities to improve services, and to correct identified problems.

Licensed Practical Nurse (LPN) – An individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana. The LPN works under the supervision of a registered nurse.

Licensure – A determination by the Health Standards Section that a provider meets the requirements of State law to provide health care and services.

Linkage – Act of connecting a beneficiary to a specific support coordination agency or service provider.

Long Term-Personal Care Services (LT-PCS) – A Medicaid state plan service which provides assistance with ADL and IADL as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older and meet specific program requirements.

Louisiana Department of Health (LDH) - The state agency responsible for administering the state's Medicaid Program and other health-related services including aging and adult services, public health, mental health, developmental disabilities, and behavioral health services.

Louisiana Service Reporting System (LaSRS) – A secure modular web application developed by an LDH contractor to issue PAs and confirm post authorizations through EVV.

Medicaid – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by the LDH or any other state agency. (LA RS 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing

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and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the beneficiary’s activities of daily living. (La. R.S. 40:2009.14)

Neglect – The failure by a care giver responsible for an adult’s care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for their well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused (La. R.S. 15:1503).

Non-allowable costs – Costs that are not based on the reasonable cost of services covered under Medicare/Medicaid and are not related to the care of beneficiaries.

Nursing Facility (NF) – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides intermediate, skilled nursing, and/or long term care for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within the Louisiana Department of Health that is responsible for the management and oversight of certain Medicaid home and community-based services waiver programs, state plan programs, adult protective services for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

OAAS Regional Office – One of nine administrative offices within the Office of Aging and Adult Services.

Office of Behavioral Health (OBH) – The office in LDH responsible for services to individuals with behavioral or addictive disorders.

Office of Public Health (OPH) – The office in LDH responsible for personal and environmental health services.

Office for Citizens with Developmental Disabilities (OCDD) – The office in LDH responsible for services to individuals with developmental disabilities.

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Personal Outcome – Result achieved by or for the waiver beneficiary through the provision of services and supports that make a meaningful difference in the quality of the individual’s life.

Person-Centered – An approach used in the assessment and planning processes that considers a beneficiary’s personal experiences and preferences.

Plan of Care (POC) – A written person-centered plan developed by the beneficiary, their authorized representative and support coordinator based on assessment results. The plan specifies services to be accessed and coordinated by the support coordinator on the beneficiary’s behalf and includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Program of All-Inclusive Care for the Elderly (PACE) – Program which coordinates and provides all needed preventive, primary health, acute and long-term care services to qualified beneficiaries age 55 and older in order to enhance their quality of life and allow them to continue to live in the community.

Progress Notes – Documentation of the delivery of services, activities, and/or observations to record important information as applicable.

Provider – An entity that delivers Medicaid services under a provider agreement with LDH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other LDH office. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other LDH funding source.

Provider Enrollment – See “Enrollment”.

Reassessment – See “Assessment”. The re-assessment is completed at least annually for waiver beneficiaries and when a significant status change occurs in order to update the POC and/or ISP.

Registered Nurse (RN) – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible beneficiary.

Responsible Representative – An adult who has been designated by the beneficiary to act on their behalf with respect to their services. The written designation of a responsible representative does

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not give legal authority for that individual to independently handle the beneficiary's business without the beneficiary's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Self-neglect – The failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)

Service Logs - Documentation of the delivery of PAS and Caregiver Temporary Support services, activities and observations of a beneficiary.

Sexual Abuse – Any non-consensual sexual activity between a beneficiary and another individual. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; request, suggestion, or encouragement by another person for the beneficiary to perform sex with any other person when the beneficiary is not capable of or competent to refuse.

Support Coordination – Services provided to eligible beneficiaries to help them gain access to the full range of needed services including medical, social, educational, housing, and other support services regardless of the funding source for these services. Activities also include assessment, Plan of Care development, service monitoring, critical incident management, and transition/discharge.

Support Coordinator – An individual who meets the required qualifications and who is employed by a Support Coordination Agency.

Transition – A shift from a beneficiary's current services to another appropriate level of services, including discharge from all services.

Waiver Opportunity – An offer made to an individual on the CCW Request for Services Registry. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.