LOUISIANA DEPARTMENT OF HEALTH

FISCAL/EMPLOYER AGENT

Chapter Three of the Medicaid Services Manual

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State of Louisiana
Bureau of Health Services Financing

FISCAL EMPLOYER AGENT

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OVERVIEW

Self-direction is a service delivery option which allows beneficiaries to become the employers of the direct service workers (DSWs) they choose to hire to provide supports for them. As the employer, the beneficiary, or their authorized representative is responsible for recruiting, training, supervising, and managing the DSWs they choose to hire.

A required component of the self-direction option is the use of a fiscal/employer agent (F/EA) to perform the beneficiary's employer-related financial management services (FMS). Beneficiaries must utilize support coordination services for the development of the plan of care (POC), budget planning, ongoing evaluation of supports and services, and for organizing the unique resources the beneficiary needs.

NOTE: An individual who is unable to make decisions independently or who does not have an authorized representative as their willing decision maker is not eligible to enroll in the self-direction option. The beneficiary is not allowed to receive supported independent living (SIL) services at the same time as they receive the self-direction option.

FINANCIAL MANAGEMENT SERVICES

The Medicaid self-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows the beneficiary, or their authorized representative, if applicable, to have decision-making authority and to take direct responsibility for managing all aspects of service delivery in a person-centered planning process with the assistance of a system of available supports.

Self-direction promotes personal choice and control over the delivery of waiver and State Plan services, including who provides the services and how services are provided. Some self-directing program beneficiaries share authority with or delegate authority to an authorized representative (i.e., a family member, friend, or other persons close to the beneficiary). The designation of an authorized representative enables minor children and adults with cognitive impairments to participate in self-direction programs.

The self-direction option provides beneficiaries the ability to serve as the employer of record, including having their own federal employer identification number (FEIN). Beneficiaries choosing to exercise employer authority rights have the responsibility to recruit, hire, train, supervise, discipline, and fire their direct service workers (DSWs).

Beneficiaries or an authorized representative identified as able to self-direct their services through the self-direction waiver option must do so by selecting a fiscal/employer agent (F/EA) provider to provide financial management services (FMS).

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) enrolls F/EAs through the Medicaid fiscal intermediary and establishes the minimum standards for participation. These standards provide the core requirements for FMS provided under the for home and community based services (HCBS) waiver programs administered by the Office of Aging and Adult Services (OAAS), the Office for Citizens with Developmental Disabilities (OCDD), and BHSF:

1. Community Choices Waiver (CCW);
2. New Opportunities Waiver (NOW);
3. Residential Options Waiver (ROW); and
4. Children’s Choice Waiver (CC).

The F/EA will provide FMS for beneficiaries eligible for self-directed services that include the following:

1. Ensure current and initial beneficiaries are provided with information they need to effectively participate in this option;

2. Management of fiscal employment and/or budget responsibilities, including the following:

    a. Understand billing and documentation responsibilities;

    b. Purchase approved goods and services, if allowed under the current waiver;

    c. Track and monitor individual budget expenditures; and

    d. Identify expenditures that are over or under the budget.

3. Provide current utilization information to ensure self-directed services are not exceeded beyond the prior authorization cap;

4. Verification of qualifications (e.g., background checks, exclusion checks, etc.) for employees hired by the employers;

5. Process employer-related payroll and required taxes in accordance with state, federal, and Medical regulation regarding vendor F/EA:

    a. Withholding and filing federal, state, local, and unemployment taxes;

    b. Purchasing workers' compensation or other forms of insurance;

    c. Collecting and processing worker timesheets;

    d. Calculating and processing employee benefits; and

    e. Issuing payroll checks.

6. Ensure all questions from beneficiaries, the support coordinator, and Louisiana Department of Health (LDH) staff are responded to in a timely manner.

Service Limitations

FMS providers must not:

1. Limit or restrict the beneficiary's choices of service or support providers; nor

2. Assist in the development of the beneficiary's plan of care (POC).

Service Limits

Each HCBS waiver has specific, services approved by the Centers for Medicare and Medicaid Services (CMS) with established definitions, provider qualifications, benefits, and limitations. Beneficiaries must follow the specific requirements and limitations for their assigned waiver program as authorized on their approved individualized service plan (ISP)/POC when directing their care.

All services must be prior authorized and coordinated by LDH/OCDD/OAAS, arranged for and provided under the beneficiary, designated authorized representatives, or legally responsible party's written authority, and paid through an enrolled FMS consistent with and not exceeding the individual's ISP/POC.

Services should provide necessary assistance to beneficiaries in their home and community. Home is considered where the beneficiary makes their residence and must not be defined as institutional in nature.

The following individuals are prohibited from being providing supports and services to a beneficiary:

1. Parent or legal guardian for the minor waiver beneficiary and/or the participant's spouse;

2. Court-appointed guardian or durable power of attorney; and

3. Authorized representatives, legally responsible individuals, and legal guardians.

   Note: Authorized representatives, legally responsible individuals, and legal guardians may be the employers in the self-directed option but may not also be the employees.

A DSW may not perform any duties not identified as a necessary task in the ISP/POC or approved by the beneficiary's physician and delegated by the beneficiary or authorized representative with the authority to direct services.

Family members who are employed in the self-directed option must:

1. Meet the same standards as direct support staff that are not related to the beneficiary; and

2. Must not exceed a total of 40 hours per week/per beneficiary when employed in the self-directed option, if they reside in the home with the beneficiary.

If the beneficiary requires an authorized representative's assistance with the self-direction option, the authorized representative must live and be a resident of Louisiana.

Termination of the Self-Direction Service Delivery Option

Termination of participation in the self-direction service delivery option requires a revision of the comprehensive plan of care (CPOC), the elimination of the F/EA and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

BENEFICIARY REQUIREMENTS

Beneficiaries/employers participating in self-directed option must:

1. Be enrolled in a 1915c home and community-based services (HCBS) waiver program administered through:

    a. Office of Aging and Adult Services (OAAS)-Community Choices Waiver (CCW); or

    b. Office for Citizens with Developmental Disabilities (OCDD):

        i. Children's Choice Waiver (CC);

        ii. New Opportunities Waiver (NOW); and

        iii. Residential Options Waiver (ROW).

2. Be able to participate in the self-directed option without a lapse or decline in quality of care or an increased risk to their health and welfare;

3. Complete the mandatory training including rights and responsibilities of managing their own services and supports offered by the support coordinator;

4. Understand the rights, risks, and responsibilities of managing their own care, and managing and using an individual budget, or if unable to make decisions independently, have a an authorized representative who is listed on the beneficiary's plan of care (POC) who understands the rights, risks, and responsibilities of managing the care and supports of the beneficiary within the individualized budget; and

5. Be able to participate in the development and management of the approved individualized service plan (ISP)/POC. The beneficiary's annual budget is determined by the recommended service hours listed in the beneficiary's comprehensive plan of care (CPOC) to meet their needs and individual includes a potential amount of dollars within which the beneficiary or their authorized representative exercises decision-making responsibility concerning the selection of services and service providers;

6. Follow all rules and requirements pertaining to the self-direction program as outlined in the OCDD Self-Direction Handbook or the OAAS Self-Direction

Handbook.

Beneficiary Criteria

To qualify for the self-directed option, beneficiaries receiving NOW, ROW, CC, and CCW with the ability to self-direct services may receive referrals from the their support coordinator to include fiscal/employer agent (F/EA) services in the POC.

Medical Necessity

All self-direction services must indicated by the POC and support coordinator assessment as medically necessary.

SERVICE ACCESS AND AUTHORIZATION PROCESS

Diversity and Inclusion (D&I)

The Louisiana Department of Health (LDH) characterizes equity, diversity, and inclusion as representing the differences and similarities of all individuals while creating a work environment in which those same individuals are treated fairly and respectfully, have equal access to opportunities and resources, and can contribute fully to the work of LDH in a safe and welcoming environment.

LDH values diversity in its workplace, vendor network, customers, and communities. As a state agency, LDH believes that diversity contributes to the success of Louisiana and society and values the unique contributions of individuals with wide ranging backgrounds and experiences. LDH believes an inclusive culture allows our employees to contribute their best. Because of this, LDH is committed to equal opportunity and fair treatment for all.

LDH prohibits discrimination on the basis of age, race, color, gender, religion, ethnicity, disability, marital or family status, national origin, sexual orientation, veteran status, genetic information, medical condition, or any other non-merit factor. LDH is fully committed to being a model for equity, diversity, inclusion, belonging, and accessibility, where all team members are treated with dignity and respect. This principle extends to all decisions relating to recruitment, hiring, contracting, training, placement, advancement, compensation, benefits, and termination. By signing this contract, contractor acknowledges the following:

1. LDH values diversity in the workplace and that contractor agrees to value diversity in its workplace, further; and

2. Is subject to uphold this Diversity and Inclusion statement in actions related to the execution and/or fulfillment of this contract; and

3. Subject to federal and/or state laws, agrees not to discriminate on the basis of age, race, color, gender, religion, ethnicity, disability, marital or family status, national origin, sexual orientation, veteran status, genetic information, or medical condition, in any action related to the execution and/or fulfillment of this contract.

Authorization Process

Families or individuals interested in the self-direction option may contact their support coordinators. If it is determined that they are able to handle the duties, the support coordinators will add this service to the plan of care (POC).

The home and community-based services (HCBS) data management/electronic visit verification (EVV) system contractor will prior authorize self-direction services.

Changing Providers

Beneficiaries have the freedom of choice to select their fiscal/employer agent (F/EA) provider. This includes the right to transition to another F/EA agency.

The F/EA must not coerce or attempt to influence the beneficiary's choice or F/EA provider. Failure to cooperate with the beneficiary's decision to transfer to another F/EA will result in adverse action by the department.

Transfers and Discharges

Upon notice by the beneficiary or their authorized representative that the beneficiary has selected another F/EA or discontinue participation in the self-direction program, the F/EA is responsible for planning and facilitating the beneficiary's transfer or discharge.

The transfer or transition responsibilities of the F/EA shall include the following:

1. Work with the F/EA provider who the beneficiary has selected to transition by ensuring the following documents/information are submitted to the new provider:

    a. Beneficiary/employer wages;

    b. Federal employer identification number (FEIN); and

    c. State Unemployment Tax Act (SUTA) account information including username and password.

2. Ensure there is only one financial management services (FMS) provider for a given employer at any time;
3. Adhere to specific processes and procedures when transitioning a beneficiary to a new FMS provider in accordance with all federal, state, and local laws; and

4. Document the activities that are required to transition the beneficiary to the receiving F/EA provider.

When an F/EA provider closes or decides to no longer participate in the Medicaid program, the provider must give at least a 60-day written advance notice of its intent to close to LDH prior to discontinuing services. If the F/EA ceases to operate or its Medicaid enrollment is terminated, the agency must facilitate the transfer of its beneficiaries to another F/EA. The transition plan for all beneficiaries' service by the F/EA must be completed within 10 working days of the notice to LDH of the intent to close to minimize disruption of payroll services provided for the employers.

PROVIDER REQUIREMENTS

Entities wishing to provide fiscal/employer agent (F/EA) services must abide by and adhere to any federal and state law, Rule, policy, procedure, performance agreement, manual, or memorandum pertaining to the provision of F/EA services. Failure to comply with the requirements of these standards for participation may result in the following actions including, but not limited to:

1. Recoupment of funds;

2. Sanctions for violations/non-performance as outlined in the performance agreement;

3. Citation of deficient practice and plan of correction submission;

4. Removal from the F/EA freedom of choice list; or

5. Decertification as an F/EA agency and termination of the agency's Medicaid provider enrollment.

Upon request by the Louisiana Department of Health (LDH), F/EAs must make available legal ownership documents, required records, and information reasonably related to the assessment of compliance with these requirements for review.

F/EA agencies shall, at a minimum:

1. Demonstrate administrative capacity and the financial resources to provide all core elements of financial management services (FMS) and ensure effective service delivery in accordance with state and federal requirements;

2. Have appropriate agency staff attend trainings, as mandated by LDH;

3. Document and maintain records in accordance with federal and state regulations governing confidentiality and program requirements;

4. Assure that the F/EA will not provide both FMS and support coordination or personal care services in Louisiana; and

5. Establish policies and procedures relative to the reporting of abuse, neglect, exploitation, and extortion of beneficiaries, pursuant to the provisions of R.S.

15:1504-1505, R.S. 40:2009.20 and any subsequently enacted laws and ensure that staff complies with these regulations.

Systems/Software Requirements

The F/EA must comply with all of LDH's systems/software requirements, including the following:

1. Transmit all non-proprietary data which is relevant for analytical purposes to LDH on a regular schedule in XML format. Final determination of relevant data will be made by LDH based on collaboration between all parties. The schedule for transmission of the data will be established by LDH and dependent on the needs of LDH related to the data being transmitted. XML files for this purpose will be transmitted via Secure File Transfer Protocol (SFTP) to LDH. Any other data or method of transmission used for this purpose must be approved via written agreement by all parties;
2. Procure and maintain hardware and software resources which are sufficient for it to successfully perform the services outlined in Section 3.1 Financial Management Services of this manual chapter;
3. Adhere to state and federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support F/EA requirements;
4. Responsible for all expenses required to obtain access to LDH systems or resources and expenses required for LDH to obtain access to the F/EA's systems or resources, unless explicitly stated to the contrary. Such expenses are inclusive of:
    a. Hardware;
    b. Software;
    c. Network infrastructure; and
    d. Licensing costs.
5. Encrypt all confidential or protected health information to FIPS 140-2 standards when at rest or in transit;
6. Ensure appropriate protections of shared personally identifiable information ("PII"), in accordance with 45 CFR §155.260;

7. Ensure that its system is operated in compliance with the Centers for Medicare and Medicaid Services' (CMS) latest version of the Minimum Acceptable Risk Standards for Exchanges (MARS-E) Document Suite;

8. Provide and enforce multi-factor authentication if the F/EA utilizes a VPN site-to-site tunnel and also has remote users who access CMS data;

9. F/EA owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (health information technology for economic and clinical and health (HITECH), health insurance portability and accountability (HIPAA) part 164);

10. Receive written approval from LDH prior to the use of flash drives or external hard drives for storage of LDH data and must adhere to FIPS 140-2 hardware level encryption standards; and

11. All utilized computers and devices must:

    a. Be protected by industry standard virus protection software that is automatically updated on a regular schedule;

    b. Have installed all security patches which are relevant to the applicable operating system and any other system software; and

    c. Have encryption protection enabled at the operating system level.

Certification Requirements

It is unlawful to operate as an F/EA without being certified by the LDH. In order to provide FMS, the F/EA must:

1. Be certified through completion of a readiness review and meet the standards for participation requirements as set forth by LDH;

2. Sign a performance agreement with LDH;

3. Enroll as a statewide Medicaid F/EA to provide services for the Office for Citizens with Developmental Disabilities (OCDD) and the Office of Aging and Adult Services (OAAS)-administered home and community-based services; and

4. Comply with all policies and procedures set forth by LDH.

Certification Issuance

A certification issued by LDH shall:

1. Be issued only to the entity named in the certification application;

2. Be valid only for the F/EA to which it is issued after all applicable requirements are met;

3. Enable the F/EA to provide FMS for OCDD and OAAS-administered HCBS waivers statewide; and

4. Be valid indefinitely, unless revoked, suspended, modified or terminated.

Certification Refusal or Revocation and Fair Hearing

A certification may be revoked or refused if applicable certification requirements, as determined by LDH, have not been met. Certification decisions are subject to appeal and fair hearing, in accordance with R.S. 46:107(A) (3).

Certification Review

Compliance with certification requirements is determined by LDH through its F/EA monitoring processes. Monitors must be given access to data upon request by LDH to ensure the F/EA continues to meet certification requirements.

Administration and Organization

Governing Body

The F/EA shall have an identifiable governing body with responsibility for and authority over the policies and activities of the F/EA.

The F/EA shall have documents identifying all members of the governing body, their addresses, their terms of membership, and officers of the governing body.

The governing body of the F/EA shall:

1. Ensure continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

2. Ensure the F/EA is adequately funded and fiscally sound;

3. Review and approve the F/EAs annual budget; and

4. Designate a person to act as administrator and delegate sufficient authority to this person to manage the F/EA.

The F/EA shall maintain an administrative file that includes:

1. Documents identifying the governing body;

2. List of members and officers of the governing body, along with their addresses and terms of membership;

3. Minutes of formal meetings and by-laws of the governing body, if applicable;

4. Documentation of the agency's authority to operate under state law;

5. Organizational chart of the agency which clearly delineates the line of authority;

6. All leases, contracts and purchases-of-service agreements to which the agency is a party;

7. Insurance policies;

8. Annual budgets and, if performed, audit reports;

9. Agency's policies and procedures; and

10. Documentation of any corrective action taken as a result of external or internal reviews.

Business Location and Operations

The F/EA shall have a business location which shall not be in an occupied personal residence. The business location must:

1. Maintain staff to perform administrative functions;

2. Maintain direct service worker/employee personnel records; and

3. Maintain beneficiary service records.

The business location must have the below:

1. Published nationwide toll-free telephone number which is available during business hours and capable of receiving messages 24 hours a day, 7 days a week, including holidays;

2. Published business telephone number answered by staff during the posted business hours;

3. Business fax number that is operational 24 hours a day, 7 days a week, including holidays;

4. Internet access;

5. Designated e-mail mailboxes to receive inquiries from Medicaid beneficiaries and LDH; and

6. Business hours of operation of 8:00 AM to 5:00 PM CST, Monday-Friday excluding official state holidays; and

7. Area to keep records and other confidential information secure and protected from unauthorized access.

Financial Management

The F/EA must:

1. Establish a system of financial management and staffing to assure maintenance of complete and accurate accounts, books and records in keeping with generally accepted accounting principles;

2. Not permit public funds to be paid or committed to be paid, to any person who is a member of the governing board or administrative personnel who may have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the agency. The F/EA shall have a written disclosure of any financial transaction with the agency in which a member of the governing board, administrative personnel, or their immediate family is involved; and

3. Have and maintain documented evidence of an available line of credit of at least one million dollars ($1,000,000) or a cash reserve sufficient to cover the cost of two payroll cycles.

Policy and Procedures

The F/EA shall have written policies and procedures approved by the owner or governing body which must be implemented and followed that address at a minimum the following:

1. Confidentiality and confidentiality agreements;

2. Security of files;

3. Publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation and kickbacks;

4. Personnel;

5. Grievance procedures;

6. Emergency preparedness;

7. Procedures for reporting suspected abuse, neglect, exploitation, and extortion;

8. Procedures for reporting suspected fraud;

9. Documentation; and

10. Enrollment/disenrollment procedures.

Organizational Communication

The F/EA must:

1. Establish procedures to assure adequate communication among staff to provide continuity of services to the beneficiary and to facilitate feedback from staff, beneficiaries, families, and when appropriate, the community;

2. Have brochures and make them available to LDH or its designee. The brochures must include the following information:

    a. Toll-free number and email address to direct customer service questions or to receive assistance;

    b. Information on how to make a complaint if they are dissatisfied with F/EA services; and

3. Description of the F/EA, services provided, current mailing and physical addresses, website information, and the F/EA's toll-free number.

Fiscal Employer Agent Requirements

The F/EA must comply with requirements for FMS in self-direction, including but not limited to:

1. Verifying qualifications of employers and support workers;

2. Processing payroll including applying applicable withholds and filing/paying all required state and federal income taxes;

3. Disbursing payment to direct support workers;

4. Setting up accounting records to track expenses;

5. Setting up procedures for processing payroll and non-labor items;

6. Maintaining all records related to the direct support worker's payroll, taxes and benefits;

7. Producing and sending required reports to LDH;

8. Providing support to self-direction employers;

9. Billing the LDH fiscal intermediary for Medicaid service claims and making refunds to LDH as appropriate;

10. Resolving all billing discrepancies timely;

11. Utilizing an LDH approved payroll calendar that addresses tax obligations; and

12. Utilizing a system capable of capturing, recording, and tracking service, payroll, and tax information.

Beneficiary/Employer Rights

Each F/EA's written policies and procedures, at a minimum, shall ensure the beneficiary/employer's right to:

1. Confidentiality;

2. Privacy;

3. Impartial access to F/EA services regardless of race, religion, sex, ethnicity, or disability;

4. Access to the interpretive services, translated material and similar accommodations as appropriate;

5. Access to their records upon the beneficiary's written consent for release of information;

6. Explanation of the nature of services to be received;

7. File a complaint or grievance without retribution, retaliation or discharge;

8. Access to information related to tracking their budget and service balance; and

9. Discontinue services with their F/EA provider and choose another provider.

Grievances

The F/EA shall establish and follow a written grievance procedure to be used to process complaints by employers, their family member(s), or a legal representative that is designed to allow employers to make complaints without fear of retaliation. The written grievance procedure shall be provided to the employer.

STAFFING AND TRAINING

The fiscal/employer agent (F/EA) qualifications delineated in this section are dictated by the needs of the population to be served, and by the duties and responsibilities inherent in the provision of services defined by the Louisiana Department of Health (LDH). LDH has established these staffing requirements to maintain an adequate level of quality, efficiency, and professionalism of all services to comply with the provisions of the self-direction program.

F/EA providers must:

1. Maintain sufficient staff to comply with the LDH policies and regulations of the self-direction program;

2. Employ at least one staff member with a Bachelor's degree in accounting and five years of applicable experience, or a Master's degree in accounting and two years of applicable experience;

3. Have on staff a database administer and sufficient programmers to ensure that systems comply with program requirements and are flexible enough to accommodate changes to those requirements;

4. Designate a project director for who will have day-to-day authority to manage the overall operations. The project director will be available to LDH by telephone, e-mail, and video conferencing during regular business hours;

5. Ensure all staff supporting the self-direction program are not excluded from participating in Medicaid by confirming each staff's name and social security number are not included on the LA Adverse Actions List and Office of Inspector General (OIG) Exclusion list; and

6. Ensure that staff is available at times which are convenient and responsive to the needs of beneficiaries and their families.

In the event LDH determines that the F/EA staffing levels do not conform to the above requirements, LDH shall advise the F/EA in writing and the F/EA must submit a corrective action plan within five business days to describe how the deficiency(ies) will be remedied and is subject to LDH approval.

RECORD KEEPING

Components of Record Keeping

All fiscal/employer agent (F/EA) records must be maintained in an accessible, standardized order and format at the enrolled office site. The F/EA must have sufficient space, facilities, and supplies to ensure effective record keeping. Sufficient records must be retained to document compliance with Louisiana Department of Health (LDH) requirements for the beneficiary served and the provision of fiscal management services (FMS).

The following must be maintained:

1. Separate record for beneficiary that fully documents FMS for which payments have been made; and

2. Sufficient documentation to verify that prior to payment each charge was due and proper.

Confidentiality and Protection of Records

All records, including but not limited to administrative and beneficiary files, must be secured against loss, tampering, destruction, or unauthorized use. Providers must comply with all laws and regulations concerning confidentiality which safeguard information and patient/client confidentiality.

Employees of the F/EA must not disclose or knowingly permit the disclosure of any information concerning the agency, the beneficiaries, or their families, directly or indirectly, to any unauthorized person. The F/EA must safeguard the confidentiality of any information that might identify the beneficiaries or their families. The wrongful disclosure of such information may result in the imposition by LDH of available sanctions pursuant to Medicaid certification authority or the imposition of a monetary fine and/or imprisonment by the United States Government pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. The information may be released only under the following conditions:

1. Court order;

2. Beneficiary’s written informed consent for release of information;

3. Written consent of the individual to whom the beneficiary’s rights have been devolved when the beneficiary has been declared legally incompetent; or

4. Written consent of the parent or legal guardian when the beneficiary is a minor.

The F/EA must, upon request, make available information in the case records to the beneficiary or legally responsible representative. If, in the professional judgment of the administration of the F/EA, it is felt that information contained in the record would be damaging to the beneficiary, or reasonably likely to endanger the life or physical safety of the beneficiary, that information may be withheld. This determination must be documented in writing.

The F/EA may charge a reasonable fee for providing the above records. The cost of copying cannot exceed the community's competitive copying rate.

Material from case records may be used for teaching or research purposes, the development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, if names are deleted and other similar protected health information is redacted or deleted.

A system must be maintained that provides for the control and location of all beneficiary records. Beneficiary records must be located at the enrolled site.

Under no circumstances should providers allow staff to take beneficiary's case records from the facility.

State and Federal Agency Review

The F/EA must make all administrative, personnel and beneficiary records available to LDH and appropriate state and federal personnel at all reasonable times to determine compliance with any federal or state law, rule, or regulation promulgated by LDH.

Retention of Records

The F/EA must retain administrative, personnel and beneficiary records for whichever of the following time frames is longer:

1. Six (6) years from the date of the last payment period; or

2. Until records are audited and all audit questions are resolved.

NOTE: Upon agency closure, all F/EA records must be maintained according to applicable laws, regulations and the above record retention requirements along with copies of the required documents transferred to the new agency. The new F/EA must bear the cost of copying, which cannot exceed the community's competitive copying rate.

Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements, LDH administrative rules and Medicaid enrollment agreements.

Employer Records

Employer/employee records must be:

1. Stored securely and protected in accordance with HIPAA requirements at the F/EA's place of business; and

2. Maintained employer and employee records for at least six years or longer when required by state or federal law.

Beneficiary Records

The F/EA must have a separate written record for each beneficiary served by the agency. It is the responsibility of the provider to have adequate documentation of the fiscal management services offered to waiver beneficiaries for the purposes of continuity of care, support for the individuals and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an ongoing chronology of FMS received and undertaken on behalf of the beneficiary.

All beneficiary records and location of documents contained therein must be maintained consistently in the F/EA's office. Records must be appropriately maintained so that current material can be located in the record.

The Office of Citizens with Developmental Disabilities (OCDD) does not prescribe a specific format for documentation, but all components outlined below must be in each beneficiary's active record.

Organization of Records, Record Entries and Corrections

The organization of individual beneficiary records and the location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record.

All entries and forms completed by staff in beneficiary records must be legible, written in ink and include the following:

1. Name of the person making the entry;
2. Signature of the person making the entry;
3. Functional title of the person making the entry;
4. Full date of documentation; and
5. Supervisor review, if required.

Any error made by the staff in a beneficiary's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a beneficiary's records.

Components of Beneficiary Records

The beneficiary record must consist of the active record and the agency's storage files or folders. The active record must contain, at a minimum, the following information:

1. Identifying information on the beneficiary that is recorded on a standardized form to include the following:
    a. Name;
    b. Home address;
    c. Telephone number;
    d. Date of birth;
    e. Sex;
    f. Name and phone number of preferred hospital;
    g. Closest living relative;
    h. Marital status;
    i. Date approved for self-direction; and
    j. Court and/or legal status, including relevant legal documents, if applicable.

2. Medicaid eligibility information;

3. Copy of assurances of freedom of choice of providers, beneficiary rights and responsibilities, confidentiality, and grievance procedures, etc. signed or initialed by the beneficiary;

4. Copy of all critical incident reports, if applicable;

5. Formal grievances filed by the beneficiary;

6. Reason for case closure and any agreements with the beneficiary at closure;

7. Copies of all pertinent correspondence;

8. At least six (6) months (or all information if services provided less than six (6) months) of current pertinent information relating to services provided;

   NOTE: Records older than six (6) months may be kept in storage files or folders, but must be available for review; and

9. Any other pertinent documents.

Discharge Summary for Transfers and Closures

A discharge summary details the beneficiary's progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a beneficiary's discharge. The discharge summary in the service log may be used by the support coordinators and direct service providers to meet the documentation requirement.

PROGRAM MONITORING/QUALITY ASSURANCE AND IMPROVEMENT

The Louisiana Department of Health (LDH) is responsible for setting the standards for monitoring fiscal/employer agent (F/EA) providers and administering sanctions for failure to meet the minimum standards of participation. Services offered by the F/EA will be are closely monitored on an on-going basis as outlined in the performance agreement to assure compliance with Medicaid's policy as well as applicable state and federal regulations. F/EAs are required to fully cooperation with LDH during the monitoring process.

F/EA responsibilities in the monitoring process include, but are not limited to:

1. Providing policy and procedure manuals;
2. Employer/employee records; and
3. Other documentation as requested.

Failure to follow Medicaid policies and practices could result in the F/EA's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

F/EAs shall cooperate with any audit requests from state or federal agencies.

Grievances

The F/EA shall establish and follow a written grievance procedure to be used to process complaints by employers, their family member(s), or a legal representative that is designed to allow employers to make complaints without F/EA of retaliation. The written grievance procedure shall be provided to the employer.

All suspected cases of abuse (physical, mental and/or sexual), neglect, exploitation or extortion must be reported to the appropriate authorities. (See Appendix E for contact information).

If the beneficiary needs emergency assistance, the F/EA shall call 911 or the local law enforcement agency.

Any other circumstances that place the beneficiary's health and well-being at risk should also be reported.

NOTE: It is the policy of LDH, Office for Citizens with Developmental Disabilities (OCDD) and Office on Aging and Adult Services (OAAS) that all critical incidents for home and community-based services (HCBS) be reported, investigated and tracked. Beneficiaries or their responsible party must report such occurrences to their support coordinator. Should the F/EA receive a complaint or a report of abuse, neglect or fraud, it must be reported to the appropriate program office, Medicaid Program Support and Waivers section and the Office of the Inspector General (OIG), if indicated.

Internal Complaint Policy

Beneficiaries must be able to file a complaint regarding their services without fear of reprisal. The F/EA shall have a written policy to handle beneficiary complaints. In order to ensure that the complaints are efficiently handled, the F/EA shall comply with the following procedures:

1. Each F/EA shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint, and resolution of the complaint;

2. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to: gathering pertinent facts from the beneficiary, the personal representative, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution;

3. The provider's administrator or designee must inform the beneficiary and/or the personal representative in writing **within 10 working days** of receipt of the complaint and the results of the internal investigation; and

4. If the beneficiary is dissatisfied with the results of the internal investigation regarding the complaint, they may continue the complaint resolution process by contacting the appropriate local governing entity (LGE) in writing, or by telephone.

If the complainant's name and address are known, the LGE will notify the complainant **within two working days** that the complaint has been received and action on the complaint is being taken.

Complainant Disclosure Statement

Louisiana R.S. 40:2009.13-40.2009.21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the home and community-based services waiver programs. When the substance of the complaint is furnished to the F/EA, it shall not identify the complainant or the beneficiary unless they consent in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

Definition of Related Terms Regarding Incidents and Complaints

The following definitions are used in the incident and complaint process:

1. Trivial report - an account of an allegation that an incident has occurred to a beneficiary or beneficiaries that causes no physical or emotional harm and has no potential for causing harm to the beneficiary or beneficiaries. (R.S. 40:2009.14);

2. Allegation of noncompliance - an accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers. (R.S. 40:2009.14);

3. Disabled person - a person with a mental, physical or developmental disability that substantially impairs the person's ability to provide adequately for their own care or protection; and

4. Incident - any situation involving a beneficiary that is classified in one of the categories listed in this section or any category of event or occurrence defined by OCDD as a critical event, and has the potential to impact the beneficiary or affect delivery of waiver services.

For additional definitions, refer to Appendix E Glossary of this manual chapter.

Administrative Sanctions for Violations for Violations/Non-Performance

Liquidated Damages

F/EAs that fail to meet the performance standards specified in the provider enrollment documentation and performance agreement may be assessed liquidated damages.

Liquidated damages will be used to reduce the Department's payments to the F/EA for FMS. If liquidated damages exceed the amounts due from LDH, the F/EA will be required to make cash payments for the amount in excess.

If it is in the best interest of LDH, the assessment of liquidated damages may be delayed. LDH may give notice to the F/EA of a failure to meet performance standards but delay the assessment of liquidated damages in order to the F/EA to cure the deficiency. If the F/EA subsequently fails to remedy the deficiency to the satisfaction of LDH, LDH may assess the liquidated damages that have been incurred, even following Medicaid enrollment termination.

Liquidated damages are defined as:

1. **Late submission of any required report:**
   One hundred dollars ($100) per working day, per report;

2. **Failure to maintain all beneficiary files and perform all file updates according to the requirements in the performance agreement:**
   Five hundred dollars ($500) per occurrence; and

3. **Failure to meet performance outcomes as outlined in the performance agreement:**
   Reduce the F/EA's per member per month (PMPM) payments by up to 20 percent.

The decision to impose liquidated damages may include consideration of some or all of the following factors:

1. Duration of the violation;

2. Whether the violation (or one that is substantially similar) has previously occurred;

3. F/EA's history of compliance;

4. Severity of the violation and whether it imposes an immediate threat to the health or safety of the beneficiary(s); and/or

5. "Good faith" exercised by the F/EA in attempting to stay in compliance.

In order to remain in good standing with Medicaid and eligible to continue the provision of services under the Medicaid Provider Agreement, the F/EA must comply with the all requirements listed in Performance Agreement. If the F/EA is determined to be in violation and/or non-compliance with those requirements, Medicaid reserves the right to impose sanctions on the F/EA, with or without prior notice.

Sanctions may be imposed in the following circumstances:

1. Retaliation aimed at beneficiary/family members for complaints against the F/EA;

2. Negligence directly or indirectly caused by failure to comply with mandating reporting requirements resulting in serious harm or death to the beneficiary;

3. Engaging in a pattern of recurring or continuing non-compliance;

4. Failure to implement an emergency preparedness and response plan in the event of a disaster; and/or

5. Failure to cooperate in assisting the beneficiary and the receiving F/EA to assure a smooth transition, by assuring that the receiving F/EA, receives copies of the beneficiary's records.

Sanction Determinations

The following factors will be considered in determining sanctions to be imposed:

1. Seriousness of the violation;

2. Extent of the violation;

3. History of prior violations;

4. Pattern of non-compliance; and

5. Any other factors deemed critical by LDH.

Sanctions may include, but are not limited to, the following which are **binding** and **not subject to appeal**:

1. Written warning;

2. Written mandate for documentation of acceptable remediation plan/demonstration of compliance with rules/regulations/agreement;

3. Impose training and accountability measures;

4. Impose further performance requirements;

5. Moratorium on admissions and/or expansion of services (i.e. Removal from FOC list); and

6. Removal of existing beneficiaries. If Medicaid determines that removal of existing beneficiaries is necessary, the F/EA must cooperate in the transfer of the beneficiaries to a new F/EA or face additional sanctions.

In addition to the measures described above, sanctions may also include, but are not limited to, the following, which are subject to an administrative appeal:

1. Suspension of payments in whole or part for a specific time period;

2. Recoupment;

3. Denial of reimbursement for undocumented services;

4. Impose daily, weekly, or monthly fines;

5. Medicaid provider enrollment suspension/limitation/revocation; and/or

6. Termination of the Medicaid Provider Agreement.

In addition, if action or inaction on the part of the F/EA result in a federal disallowance, the F/EA shall be held liable to recoupment of those amounts.

Due Date of Monetary Sanctions

Impositions of any damage shall not be suspensive. Any and all monetary sanctions/recoupment shall become due and payable upon written notification from LDH. Failure to remit payment within ten (10) working days may result in withholding of payment until all outstanding monetary sanctions/recoupment are paid, unless an administrative appeal is pending.

If LDH should prevail at the administrative appeal, payment is due within ten (10) working days from the date of the decision. Failure to remit payment within ten (10) working days from the date of decision may result in withholding of the F/EA's payments until all outstanding fines are paid, and may result in additional non-monetary sanctions.

Appeals

Specified sanctions administered by Medicaid in accordance with the performance agreement may be appealed. The F/EA has a right to an administrative hearing. A request for an administrative hearing must be received within 30 days from the date of written notice of the sanction. The request must be made in writing and mailed or faxed directly to:

REIMBURSEMENT

Individuals receiving waiver services cannot bill Medicaid directly for approved services. The fiscal/employer agent (F/EA) is the only entity that can submit claims and received payments from the state on behalf of the beneficiary. These payments are used to pay direct care workers and for approved services and goods, if applicable.

F/EAs are reimbursed based on a monthly unit of fiscal management service (FMS). The service is included in the plan of care (POC) and procedure code is prior authorized by the Medicaid data contractor. **Prior authorization is required**. **No services are reimbursed unless prior authorized.**

Electronic Visit Verification Requirements

The F/EA must have a user-friendly electronic visit verification (EVV) system in place that complies with the 21st Century Cures Act.

The EVV system must verify the following:

1. Type of service provided;
2. Individual receiving the service;
3. Individual providing the service;
4. Date of service;
5. Location of the service –geolocation; and

   NOTE: Electronic check in/check out information including geolocation data collection is required. See technical requirements: Data Integration Process and Data Bridge Elements.

6. Time the service begins and ends.

Services may be verified via smart phone, telephony (landline from beneficiary's home), or a fixed visit verification device in the beneficiary's home. Other methods of verification may be submitted to the Louisiana Department of Health (LDH) for consideration and approval. F/EAs should have an alternative time collection method that has successfully passed the data integration process to connect to the designated EVV system, and is approved by the Department, should the EVV system become unavailable.

The F/EA is responsible for ensuring the system used meets the requirements specified in the LDH Attestation for Third Party EVV systems. The system must have the capability to interface with LDH's EVV system.

Prior to "go-live", the F/EA's system and its interface must pass testing required by the data integration process.

DEVELOPMENTAL DISABILITY LAW

A developmental disability is defined by the Developmental Disability Law (Revised Statutes 28:452.1). The law states that a developmental disability means either:

1. A severe chronic disability of a person that:

    a. Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments;

    b. Is manifested before the person reaches age twenty-two;

    c. Is likely to continue indefinitely;

    d. Results in substantial functional limitations in three or more of the following areas of major life activity:

        i. Self-care;

        ii. Receptive and expressive language;

        iii. Learning;

        iv. Mobility;

        v. Self-direction;

        vi. Capacity for independent living; or

        vii. Economic self-sufficiency.

    e. Is not attributed solely to mental illness; and

    f. Reflects the person's need for a combination and sequence of special, interdisciplinary, generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

OR

2. A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high

probability of resulting in criteria that, later in life, may be considered to be a developmental disability.

EMERGENCY PREPAREDNESS

The fiscal/employer agent (F/EA), regardless of the architecture of its systems, must develop and be continually ready to invoke an all-hazards preparedness plan to protect the availability, integrity, and security of data during unexpected failures or disasters (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.

The all-hazards preparedness plan shall include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc., in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to information technology (IT), as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the all-hazards planning process is a best practice.

At a minimum, the all-hazards preparedness plan must address the following scenarios:

1. Central computer installation and resident software are destroyed or damaged;

2. System interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage; and

3. System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system.

The all-hazards preparedness plan must specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster. The following minimum criteria are required:

1. System restoration within 24 hours;

2. Two physical locations for maintaining data; and

3. Backups of all system data every 24 hours.

The F/EA shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to Louisiana Department of Health (LDH) that it can restore system functions. In the event the F/EA fails to demonstrate through these tests that it can restore system functions, the F/EA shall be required to submit a corrective action plan to LDH describing how the failure shall be resolved within ten (10) business days of the conclusion of the test.

CLAIMS FILING

Billing and Claims

Payments/reimbursement for self-direction services will be made through claims submitted by the fiscal/employer agent (F/EA) to the Medicaid fiscal intermediary (FI) in accordance with the below methodology.

Prior to submission to the Medicaid FI, claims must be submitted through a third party electronic visit verification (EVV) vendor that has a business relationship with the F/EA.

Overlapping Dates of Services

Dates of service on the claim must match the dates approved on the plan of care (POC) and cannot overlap.

Same Day Service When Hospitalized or in a Long-Term Care (LTC) Facility

In certain situations, home and community-based services (HCBS) approved on the POC and provided the same day a beneficiary is hospitalized or in a nursing facility may be allowed.

Situations are limited to:

1. HCBS provided the date of admission, if provided ***prior*** to the beneficiary being admitted; and

2. HCBS provided the date of discharge, if provided ***following*** the beneficiary's discharge.

CONTACT INFORMATION

Office on Aging and Adult Services (OAAS)

Contact for the OAAS regional offices is found on the OAAS website at:
https://ldh.la.gov/index.cfm/directory/category/141

Office for Citizens with Developmental Disabilities and Local Governing Entities

Contact information for the central office and the regional local governing entities (LGEs) is found on the Office for Citizens with Developmental Disabilities (OCDD) website at:
http://dhh.louisiana.gov/index.cfm/page/134/n/137.

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Louisiana Department of Health (LDH) Health Standards Section	Report changes that affect provider license	Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 or (225) 342-0138 Fax: (225) 342-5073
Division of Administrative Law – Health and Hospitals Section	File an appeal request	Division of Administrative Law - Health and Hospitals Section P. O. Box 44033 Baton Rouge, LA 70804-4033 (225) 342-1800 Fax: (225) 342-1812
Gainwell Technologies (formerly Molina) Provider Enrollment Section	Report changes in agency ownership, address, telephone number or account information affection electronic funds transfer	Gainwell Technologies Provider Enrollment Section P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370
Gainwell Technologies (formerly Molina) Provider Relations Unit	Assistance with questions regarding billing information	Gainwell Technologies Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or 225-924-5040

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Department of Children and Family Services – Local Child Protection Hotline	Report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary under age of 18.	Refer to the Department of Children and Family Services website at: http://www/dcfs.louisiana.gov under the "Report Child Abuse/Neglect" link
Adult Protective Services	Report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary aged 18-59 or an emancipated minor.	Louisiana Department of Health Office of Aging and Adult Services 1-800-898-4910
Elderly Protective Services	Report suspected cases of abuse, neglect, exploitation or extortion of a beneficiary aged 60 or older	Governor's Office of Elderly Affairs http://goea.louisiana.gov
Louisiana State Adverse Actions List Search with DSW Registry information **And** **Office of the Inspector General**	Verification of exclusion or restriction from government funded health program and verification of findings which excludes DSW from working with waiver beneficiaries. **Note:** Provider MUST search both for each worker upon hire and every month thereafter and maintain documentation of these checks.	https://adverseactions.dhh.la.gov/ and https://exclusions.oig.hhs.gov/
Medicaid Program Integrity	Report fraud, waste or abuse.	Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://ldh.la.gov/index.cfm/page/219
Federal System Award Management	Verification of exclusion or restriction of vendors from government funded programs. **Note:** Provider MUST search upon hire and every month	https://www.sam.gov/portal/SAM/

	thereafter and maintain documentation of these checks.	
OFFICE NAME	**TYPE OF ASSISTANCE**	**CONTACT INFORMATION**
Statistical Resources, Inc.	Entity to contact regarding: LaSRS • EVV pocess prior/ post authorization billing Issues.	11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501

GLOSSARY/ACRONYMS

The following is a list of abbreviations, acronyms and definitions used in the Fiscal/Employer Agent (F/EA) manual chapter:

Appeal – A due process system of procedures, which ensures that a beneficiary will be notified of, and have an opportunity to contest, a Louisiana Department of Health (LDH) decision.

Assessment – One or more processes 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 requires waiver services as well as the development of the plan of care (POC).

Authorized Representative – A person designated by a beneficiary (by use of a designation form) to act on their behalf with respect to their services.

Beneficiary – An individual who has been certified for medical benefits by the Medicaid program. A beneficiary certified for Medicaid waiver services may also be referred to as a beneficiary.

Bureau of Health Services Financing (BHSF) – The Bureau within the Louisiana Department of Health (LDH) responsible for the administration of the Louisiana Medicaid Program.

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid, Medicare and State Children's Health Insurance Program (SCHIP).

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 nursing facility level of care requirements.

Corrective Action Plan – Written description of action a direct service provider agency plans to take to correct deficiencies identified by the local governing entity (LGE), Office for Citizens with Developmental Disabilities (OCDD), Office of Aging and Adult Services (OAAS), or LDH.

De-certification – Removal of a beneficiary from the waiver by LDH due to the inability of waiver services to ensure a beneficiary's health and safety in the community or due to non-compliance with waiver requirements by the beneficiary. Decertification of a waiver beneficiary is subject to review by the State Office review panel prior to notification of appeal rights and subsequent termination of waiver services.

Developmental Disability – See Appendix A.

Direct Support Worker (DSW) – A person who is paid to provide direct services and active supports to a beneficiary.

Discharge – A beneficiary's removal from the waiver.

Eligibility – The determination of whether or not a person qualifies to receive waiver services based on meeting established criteria for the target group as set by LDH.

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.

Enrollment - F/EAs or any agency enrolling as a Medicaid provider/agent.

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.

Fiscal/Employer Agent (F/EA) – An entity which delivers fiscal management services to self-directed waiver beneficiaries under an agreement with LDH/Medicaid.

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.

Freedom of Choice (FOC) – The process that allows a beneficiary the choice between institutional or home and community-based services and to review all available support coordination and service provider agencies in order to freely select agencies of their choice.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule – A Federal regulation designed to provide privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals, and other healthcare providers.

Home and Community-Based Services (HCBS) – An optional Medicaid waiver program established under §1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirement of an

institutional level of care. It provides a collection of services through an approved CMS waiver that are provided in a community setting through enrolled providers of specific Medicaid services.

Individual Budget – An amount of dollars over which the beneficiary or their authorized representative exercises decision-making authority concerning the selection of services, service providers, and the amount of services.

Individualized Service Plan (ISP) – The ISP has been replaced by the provider documents contained in the POC. See the definition for POC.

Louisiana Department of Health (LDH) – The state agency responsible for administering the state's Medicaid program and other health and related services including, but not limited to, public health, behavioral health, developmental disabilities, and addictive disorder services.

LTC – Long-Term Care.

Medicaid – A federal-state medical assistance entitlement program provided under a State Plan approved under Titles XIX and XXI of the Social Security Act.

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

Monitoring – The ongoing oversight of the provision of waiver services to ensure that they are furnished according to the beneficiary's approved plan of care and effectively meet their needs.

Natural Supports – Persons who are not paid to assist a beneficiary in achieving their personal outcomes regardless of their relationship to the beneficiary.

New Opportunities Waiver (NOW) – A 1915(c) waiver program designed to provide home and community-based services to beneficiaries who otherwise would require the level of care of an ICF/ID.

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.

Office for Citizens with Developmental Disabilities (OCDD) – The operating agency responsible for the state-wide day-to-day operation and administration of the NOW, ROW, Children's Choice and Supports waivers.

Person-Centered Planning – A POC process directed and led by the beneficiary or their authorized representative designed to identify their strengths, capacities, preferences, needs, and desired outcomes.

Personal Outcomes – Results achieved by, or for, the waiver beneficiary through the provision of services and supports that make a meaningful difference in the quality of their life.

Plan of Care (POC) – A written plan designed by the beneficiary, their authorized representative, service provider(s), and others chosen by the beneficiary, and facilitated by the support coordinator which lists all paid and unpaid supports and services. It also identifies broad goals and timelines identified by the beneficiary as necessary to achieve their personal outcomes. Also included in the POC are specific actions required by the provider agency to assist in achieving the personal outcomes defined by the beneficiary are, as well as tasks to support daily living and ensure health and safety.

Plan of Correction – A plan developed by a provider in response to deficient practice citations. Required components of the Plan of Correction include the following:

1. What corrective actions will be accomplished for those waiver beneficiaries found to have been affected by the deficient practice;

2. How other beneficiaries being provided services and support who have the potential to be affected by the deficient practice will be provided corrective care resulting from the Plan of Correction;

3. The measures that will be put into place or the systemic changes that will be made to ensure that the deficient practice will not recur; and

4. How the corrective measures will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place regarding the identified deficient practice.

Prior and Post Authorization (PA) - The authorization for service delivery based on the beneficiary's approved POC. PA must be obtained before any waiver services can be provided and post authorization must be approved before services delivered will be paid.

Procedure Code – A code used to identify a service or procedure performed by a provider.

Provider/Provider Agency – An individual or entity furnishing Medicaid services under a provider and/or licensing or certification agreement.

Progress Notes – Documentation of the delivery of services, activities and observations of a beneficiary to record progress toward the goals indicated in the POC and/or ISP.

Provider – An entity which 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 office.

Reassessment – A core element of services defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and redesigning the overall POC.

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.

Request for Services Registry (RFSR) – The database that contains the demographic information, screening score(s), and protected waiver request date(s) for all individuals who request waiver services through OCDD.

Screening for Urgency of Need (SUN) – The current tool used by OCDD to determine the urgency of need of individuals on the RFSR. The score received on the SUN is used for prioritization in making waiver offers.

Single Point of Entry (SPOE) – The local governing entity (LGE) where the entry point for all developmental disability services, including home and community-based waivers, is made.

SOA – Statement of approval (previously known as a statement of eligibility or SOE). Statement issued by the SPOE confirming the date the individual has been determined to meet the Louisiana definition for developmental disability.

Support Coordination – Case management services provided to eligible waiver beneficiaries to help them gain access to the full range of needed services including medical, social, educational and other support services. Activities include, but are not limited to, assessment, POC

development, service monitoring, and assistance in accessing waiver, Medicaid State Plan and other non-Medicaid services and resources.

Support Coordinator – A person who is employed by a public or private entity compensated by the State of Louisiana through Medicaid State Plan Targeted Case Management services to create and coordinate a comprehensive POC, which identifies all services and supports deemed necessary for the beneficiary to remain in the community as an alternative to institutionalization.

Support Team – A team comprised of the beneficiary, the beneficiary's legal representative(s), family members, friends, support coordinator, direct service providers, medical and social work professionals as necessary, and other advocates, who assist the beneficiary in determining needed supports and services to meet the beneficiary's identified personal outcomes. Medical and social work professionals may participate by report. All other support team members must be active beneficiaries.

Surveillance Utilization Review System (SURS) – The program operated by the Medicaid fiscal intermediary in partnership with the Program Integrity Section, which reviews providers' compliance with Louisiana Medicaid policies and regulations, including investigating allegations of fraud, waste, and abuse.

Title XIX – The section of the Social Security Act, which authorizes the Medicaid Program.

Transition – The steps or activities conducted to support the passage of the beneficiary from existing formal or informal services to the appropriate level of services, including disengagement from all services.

Waiver – An optional Medicaid program established under Section 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care.

Waiver Service – An approved service in a home and community-based waiver provided to an eligible beneficiary that is designed to supplement, not replace, the beneficiary's natural support.