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 his/her 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.

Authorized Representative – A person designated by a beneficiary (by use of a designation form) to act on his/her behalf with respect to his/her 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 his/her 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 his/her 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 plan of care (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 his/her needs.

Natural Supports – Persons who are not paid to assist a beneficiary in achieving his/her 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 plan of care (POC) process directed and led by the beneficiary or his/her authorized representative designed to identify his/her 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 his/her life.

Plan of Care (POC) – A written plan designed by the beneficiary, his/her 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 his/her personal outcomes. Also included in the plan of care 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.