GLOSSARY

The following is a list of abbreviations, acronyms and definitions used in the Residential Options Waiver (ROW) manual chapter:

Abuse (adult/elderly) – The infliction of physical or mental 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, to such an extent that his health, self-determination, or emotional well-being is endangered. (La. R.S. 15:1503).

Abuse (child) – Any of the following acts which seriously endanger the physical, mental, or emotional health and safety of the child including:

1. The infliction or attempted infliction, or as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon the child by a parent or by any other person;

2. The exploitation or overwork of a child by a parent or by any other person; and/or

3. The involvement of a child in any sexual act with a parent or with any other person. Abuse also, includes the aiding or toleration by a parent or the caretaker of the child's sexual involvement with any other person, including the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Louisiana Children's Code Article 603).

Activities of Daily Living (ADL) – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility, and eating. The extent to which a person requires assistance to perform one or more ADLs often is a level of care criterion.

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

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.

Applicant – An individual whose written application for Medicaid or LDH funded services has been submitted to LDH but whose eligibility has not yet been determined.

Assessment – One or more processes that are 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 participant.

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

BPS – Bureau of Protective Services.

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

Change of Ownership (CHOW) – Any change in the legal entity responsible for operation of a provider agency.

Claim – A request for payment for services rendered.

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

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) Privacy Rule and by Louisiana law.

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), or LDH.

Critical Incident – An alleged, suspected or actual occurrence of: (a) abuse (including physical, sexual, verbal and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to beneficiary's health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.

De-certification – Removal of a beneficiary from the waiver by OCDD 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.

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

Developmental Disability – See Appendix A.

Diagnosis and Evaluation (D&E) – A process conducted by an appropriate professional to determine a person's level of disability and to make recommendations for remediation.

Direct Service Provider (DSP) – A public or private licensed organization/entity that is enrolled as a Medicaid provider to furnish services to beneficiaries using its own employees (direct support workers).

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 for reasons established by OCDD.

Durable Medical Equipment (DME) – Durable medical equipment covered under the Medicaid State Plan.

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 – A computer based system that records the actual time that the provision of waiver services begins and ends. LaSRS® (Louisiana Service Reporting System) is the state sponsored system that is mandatory for some waiver services, as identified in the program manual. Providers may request permission from BHSF and OCDD to use their own EVV system for mandatory services. Approval will only be granted for EVV systems that meet minimum standards established by the department.

Emergency Backup Plan – Provision of alternative arrangements for the delivery of services that are critical to a beneficiary's well-being in the event that the direct service worker responsible for furnishing the services fails or is unable to deliver them.

Exploitation – The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of the person's or disabled adult's power of attorney or guardianship 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.

Extraordinary Care - Exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the beneficiary and avoid institutionalization.

Fiscal/Employer Agent (F/EA) – A term used by the Internal Revenue Service (IRS) for entities that perform tax withholding for employers.

Force Majeure – An event or effect that cannot be reasonably anticipated or controlled.

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 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 supports and services available 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 (self-direction option).

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

Institutionalization – The placement of a beneficiary in an inpatient facility including a hospital, group home for people with intellectual disabilities, nursing facility, or psychiatric hospital.

Interdisciplinary Team (IDT) – The group of professionals involved in assessing the needs of a high risk beneficiary and making recommendations in a team staffing for services or interventions targeted at those needs, which is also referred to as **Multi-disciplinary Team** (MDT).

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A public or private facility that provides health and habilitation services to people with intellectual disabilities. ICFs/IID have four or more beds and provide "active treatment" to their residents.

Inventory for Client & Agency Planning (ICAP) - Standardized assessment instrument that is designed to assess the status, adaptive functioning, adaptive and maladaptive behavior and service needs of an individual. The ICAP score provides input for the Individual Support Plan (ISP) development and sets the budget limitation for the individual's services plans. The ICAP is applicable to participants of all ages (infant to adult).

ICAP Acuity Level - Score from the Inventory for Client and Agency Planning (ICAP) assessment to determine reimbursement rates specific to four acuity levels of need (intermittent, limited, extensive, pervasive) identified in the ICAP. Those same acuity levels and rates are applied to ROW participants living in the community.

Level of Care (LOC) – The specification of the minimum amount of assistance that a person require in order to receive services in an institutional setting under the Medicaid State Plan.

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

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

Local Governing Entity (LGE) – The regional office, routinely referred to as the human services authority or district responsible for single point of entry, implementation, and oversight of the Residential Options Waiver on behalf of OCDD. There is one LGE for each service region. Refer to Appendix C to obtain the contact information for the LGE in your area.

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.

Louisiana Rehabilitation Services (LRS) – The agency under the Louisiana Workforce Commission charged with providing vocational rehabilitation services to qualified persons.

LTC – Long Term Care.

Medicaid – A federal-state medical assistance entitlement program provided under a State plan approved under Title XIX and XXI 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. (La. R.S. 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. The system is an organized method of

payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

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).

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.

Native Language – The language normally used by the beneficiary and his/her support network, which may include, but not limited to, American or English Sign Language and other non-verbal forms of communication.

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

Neglect (adult/elderly) – The failure of a care giver who is responsible for an adult's care or by other parties, or by the adult beneficiary's action or inaction to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her 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).

Neglect (child) – The refusal or failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment or counseling for an injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired. The inability of a parent or caretaker to provide for a child due to inadequate financial resources shall not, for that reason alone, be considered neglect. Whenever, in lieu of medical care, a child is being provided treatment in accordance with the tenets of a well – recognized religious method of healing which has a reasonable, proven record of success, the child shall not, for that reason alone, be considered neglected or abused. (Children's Code Article 603). Disagreement by the parents regarding the need for medical care, shall not by itself, be grounds for termination of parental rights. (Children's Code Article 1003).

OCDD Eligibility Determination (Form 90-L) – The form that is signed by a Louisiana licensed physician, nurse practitioner, or physician assistant and used by Medicaid to establish a Level of Care (LOC). In the Waiver programs, a beneficiary must meet an ICF/ID LOC in order to be offered a waiver opportunity.

Office for Citizens with Developmental Disabilities (OCDD) – The operating agency responsible for the day-to-day operation and administration of the OCDD Waiver programs.

Outcome – The result of performance (or non-performance) of a function or process.

Person-Centered Planning – A Plan of Care 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 – 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 that 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 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.

Pre-certification Visit – The visit the local governing entity (LGE) makes to the residence of the applicant, where at a minimum the applicant and, if appropriate, his/her representative(s) are in attendance in order to ensure that waiver planning and services, rights, responsibilities, methods of filing grievances and/or complaints, abuse/neglect and possible means of relief have been fully explained and that all parties are in agreement to move forward with waiver services.

Prior and Post Authorization (PA) - The authorization for service delivery based on the beneficiary's approved Plan of Care. Prior authorization 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.

Quality Assurance/Quality Enhancement (QA/QE) Program: - A program that assesses and improves the equity, effectiveness, and efficiency of waiver services in a fiscally responsible system, with a focus on the promotion and attainment of independence, inclusion, individuality, and productivity of persons receiving waiver services, and accomplishes these goals through standardized and comprehensive evaluations, analyses, and special studies.

Quality Improvement (QI) – The performance of discovery, remediation, and quality improvement activities in order to ascertain whether the service provider agency meets assurances, corrects shortcomings, and pursues opportunities for improvement.

Quality Management – The section within OCDD whose responsibilities include the activities to promote the provision of effective services and supports on behalf of beneficiary and to assure their health and welfare. Quality management activities ensure that program standards and requirements are met.

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 Plan of Care.

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) – A registry maintained by the OCDD that includes the dates of request and the names of individuals who have been determined to meet the Louisiana definition for developmental disability and wish to receive services in a waiver program.

Residential Options Waiver (ROW) – A 1915(c) waiver designed to provide home and community-based services to beneficiaries who otherwise would require the level of care of an ICF/IID.

Screening for Urgency of Need (SUN) – The 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.

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).

Sexual Abuse – Any sexual activity between a beneficiary and staff without regard to consent or injury; any non-consensual sexual activity between a beneficiary and another person, or any sexual activity between a beneficiary and another beneficiary, or any other person when the beneficiary lacks the capacity to consent. 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; and request, suggestion, or encouragement by another person for the beneficiary to perform sex with any other person when beneficiary is not competent to refuse.

Single Point of Entry (SPOE) – The OCDD regional offices, 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 – Services provided to eligible 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, Plan of Care development, service monitoring, and assistance in accessing waiver, Medicaid State Plan, and other non-Medicaid services and resources.

Support Coordinator – An individual meeting qualifications required by LDH who is employed by a qualified Support Coordination Agency that provides support coordination services.

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 LDH Fiscal Intermediary in partnership with the Program Integrity Section, which reviews provider's 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 supports.