GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Personal Care Services (PCS) Manual Chapter for long-term personal care services (LT-PCS) and Early and Periodic Screening Diagnostic and Treatment (EPSDT-PCS).

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

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

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

Adult Day Health Care (ADHC) 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 meet nursing facility level of care requirements and are age 65 or older, or aged 22-64 and have a physical disability.

Adult Protective Services (APS) - The office within Office of Aging and Adult Services (OAAS) that handles reports of suspected cases of abuse, neglect, exploitation or extortion of emancipated minors and adults ages 18-59.

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

Agreement to Provide Services - An agreement between the LT-PCS provider and the LT-PCS beneficiary. The agreement specifies responsibilities with respect to the provision of services.

Appeal – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination (See Fair Hearing).

Approval Date – The date the plan of care (POC) is approved.

Applicant – An individual who is requesting Medicaid services (LT-PCS or EPSDT-PCS).

Assessment – One or more processes that are used to obtain information about a person, including: their condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person meets nursing facility level of care (LOC) and requirements of the LT-PCS program. The results are used to develop the POC and an Individualized Service Plan (ISP).

Beneficiary – An individual who has been certified for PCS through the Medicaid program. A beneficiary may also be referred to as a participant.

Bureau of Health Services Financing - The bureau within the Louisiana Department of Health (LDH) that is responsible for the administration of the 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 and Medicare programs.

Certification Period – The time period that a LT-PCS beneficiary is qualified to receive services.

Chronic Needs Case – A designation granted to some EPSDT –PCS beneficiaries by the Prior Authorization Unit when the beneficiary's medical condition is such that services are expected to be continuous and remain at the level currently approved.

Community Choices Waiver (CCW) – 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 meet nursing facility LOC requirements and are age 65 or older, or aged 21–64 and have a physical disability.

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

Corrective Action Plan –A provider's written description of action required to correct identified deficiencies.

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

Direct Care Staff – Unlicensed staff who have face-to-face contact with and are paid to provide personal care and other direct service and support to qualified beneficiaries to enhance their well-being.

Elderly Protective Services (EPS) - The office within the Governor's Office of Elderly Affairs that

handles reports of suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older.

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 LT-PCS beneficiaries are receiving services authorized in their POCs, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Eligibility – The determination that a beneficiary qualifies to receive services based on meeting established criteria as set by LDH.

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

Exploitation – The illegal or improper use or management of the funds, assets or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage (La. R.S. 15:1503).

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

Early and Periodic Screening Diagnostic and Treatment (EPSDT) – Medicaid's comprehensive and preventive child health program for individuals who are under the age of 21.

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

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

Formal Services – Professional and paid services.

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

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

Hospice – An alternative treatment approach for a terminally ill patient that focuses on palliative care and support for their family.

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

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

Institutionalization – The placement of a beneficiary in an inpatient facility, including but not limited to: hospitals, nursing facilities or psychiatric hospitals.

Instrumental Activities of Daily Living (IADLs) –Routine household tasks that are considered essential for sustaining the individual's health and safety, but may not require performance on a daily basis.

Intake – The LT-PCS screening process to determine a beneficiary's need and qualification for PCS.

Level of Care Eligibility Tool (LOCET) – An algorithm-based screening tool used by OAAS and/or its designee during the initial intake screening process to determine if an applicant "presumptively" meets Nursing Facility Level of Care (NFLOC) eligibility criteria.

Licensure – A determination by HSS that a provider meets the requirements of state law to provide health care and services.

Linkage –The act of connecting a beneficiary to a specific provider.

Long-Term Care (LTC) Access Contractor – The contractor responsible for managing the authorization of services for beneficiaries in the LT-PCS program.

Long Term-Personal Care Services (LT-PCS) – An optional Medicaid State Plan service which assists with ADLs and IADLs as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older, and meet specific program requirements.

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

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

Medicaid – A federal-state financed medical assistance program authorized through Title XIX of the Social Security Act and administered under approved State Plan.

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 LDH or any other state agency(LA RS 14:70.1).

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

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

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

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

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

Office of Aging and Adult Services (OAAS) – The office within LDH responsible for the management and oversight of certain Medicaid home and community-based services (HCBS), waiver programs, State Plan programs including LT-PCS, APS for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

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

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

Program of All-Inclusive Care for the Elderly (PACE) – A capitated, managed care program under the Medicaid State Plan that coordinates and provides all needed preventative, primary health, acute

and LTC services for enrolled beneficiaries.

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

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

Personal Representative – An individual designated by a Medicaid beneficiary to act on their behalf when applying for and/or receiving Medicaid services.

Plan of Care (POC) – A written, person-centered plan developed by the beneficiary and their authorized representative based on assessment results. This document identifies each service area and outlines how services will be delivered to a beneficiary based on their preferences.

Prior Authorization Liaison (PAL) – Facilitates the prior authorization approval process for EPSDT-PCS beneficiaries who are part of the Request for Services Registry.

Progress Notes – Documentation of the delivery of services, activities, and/or observations of a beneficiary.

Provider – A licensed provider that delivers Medicaid PCS under a provider agreement with LDH.

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

Provider Enrollment – See "Enrollment".

Re-assessment –The re-assessment is completed at least once every 18 months for LT-PCS beneficiaries and when status changes occur in order to update the POC and/or ISP.

Responsible/Personal Representative – An adult who has been designated by the beneficiary to act on the beneficiary's behalf with respect to their services. The written designation of a responsible representative does not give legal authority for that individual to handle the beneficiary's business without the beneficiary's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Self-neglect – The failure, by either the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care for their own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical

treatment shall, for that reason alone, be considered to be self-neglected (La. R.S. 15:1503).

Service Area – A designated region where services are provided.

Service Period Authorization – The period that a provider is authorized to provide services.

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

Supports Waiver - A 1915(c) waiver designed to create options and provide meaningful opportunities through vocational and community inclusion for those individuals 18 years of age and older who have a developmental disability.

Transition – A shift from a beneficiary's current services to another appropriate level of services, including discharge 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 individuals who meet program requirements.