PROVIDER TYPE SPECIFIC

PACKET/CHECKLIST

(Louisiana Medicaid Program)

NURSING FACILITY

(Enrollment packet is subject to change without notice.)

Nursing Facility Provider Type

REQUIRED DOCUMENTS FOR ENROLLMENT

The following checklist shows all required documents that MUST be submitted to enroll with Fee For Service (FFS) Louisiana Medicaid. Please make certain to complete each required form in its entirety to avoid processing delays.

*Form is included in the **Basic Enrollment Packet for Entities/Businesses**.

**Forms are included here.

Completed	Document Name
☐ *	1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. PE-50 Addendum – Provider Agreement Forms (three pages).
☐ *	3. Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	4. Louisiana Medicaid Ownership Disclosure Information Forms.
☐ *	5. **(If submitting claims electronically)** Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **and** Power of Attorney Form (if applicable).
☐	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted**).
☐	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (**W-9 forms are not accepted**).
☐	8. Copy of Nursing Home License from Health Standards Section (HSS).
☐ **	*9.* Provider Agreement (four pages).
☐ **	10. Addndum to Provider Agreement, if applicable (one page).
☐	11. To report "Specialty" for this type on Section A of the PE-50, please use Code '86' (Hospitals and Nursing Homes).

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

PROVIDER AGREEMENT

FOR SKILLED NURSING FACILITY AND/OR INTERMEDIATE CARE FACILITY I OR IXX
PARTICIPATION IN THE LOUISIANA STATE MEDICAL ASSISTANCE PROGRAM (TITLE XIX)

This agreement entered into by and between: STATE OF LOUISIANA, by and through the Louisiana Department of Health, hereinafter referred to as Agency, AND _____, located at _____ hereinafter referred to as the Provider, represented herein by _____, _____ (title).

WITNESSETH

WHEREAS, persons eligible for care under the Louisiana Medical Assistance Program operating under Title XIX of the Social Security Act are in need of medical care and services in the form of institutional services,

WHEREAS, Section 1902 (a) (27) of Title XIX of the Social Security Act requires states to enter into a written agreement with every person or institution providing services under the State Medical Assistance Program,

WHEREAS, the Provider has filed an application with the Agency to provide certain medical care and services to any and all persons eligible under the Louisiana Medical Assistance Program,

WHEREAS, the Agency has licensed the Provider under the laws of the State of Louisiana,

WHEREAS, the Provider has been certified by the Licensing authority of the State of Louisiana as meeting all applicable health and safety standards for participation in the Louisiana Medical Assistance Program for provision of services for which it has been duly certified as follows:

The facility has been certified for _____.
type of service(s)

As being in full compliance with the standards of participation
As being in full compliance with the standards of participation with waiver or
As being in compliance for participation with correctable deficiencies

NOW THEREFORE, the aforesaid application is approved by the Agency subject to the following stipulations, terms and conditions:

A. The Provider agrees

1. To be in compliance with and maintain the federal and state health and safety standards relative to the type of services for which it is certified to provide.

2. To comply with all rules and regulations promulgated by Agency with regard to STANDARDS FOR PAYMENT TO SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES I AND II PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM (TITLE XIX), which are applicable to the type(s) of service for which the facility is certified and with Title XIX Cost Related Reimbursement Regulations as adopted by the Agency's Medical Assistance Program.

3. To provide the level type of care for which beneficiary is certified to need and in accordance with the level of care and type of services facility is certified to provide.

4. To keep the information in the Provider Enrollment OS Form(s) PE-50 and ownership data current with the understanding that the Provider Enrollment Form(s) and ownership data become a part of this contract and that each succeeding change in the Provider Enrollment Form constitutes an amendment to the contract and that failure to keep the information current constitutes a breach of the contract.

5. To notify the Agency prior to any change of ownership or of any transaction affecting the operation of the Provider, as defined by the Standards for Payment.

6. To accept, as payment in full, the amounts paid in accordance with established fees for services billed.

7. That Agency and Department of Health, Education, and Welfare representatives may have access to data indicating charges by Provider.

8. That no person shall, on the ground of race, color, or national origin, be subjected to discrimination, be excluded from participation in, or be denied the benefits of the services provided by the terms of this agreement, as provided in Standards for Payment.

9. That no employee or applicant for employment shall be subjected to discrimination because of race, color, religion, sex, or national origin as provided in the Standards for Payment.

10. To keep such records for the period of time specified in the Standards for Payment as are necessary fully to disclose to extent to the services provided to individuals receiving assistance under the Louisiana Medical Assistance Program.

11. To furnish the State Agency with such information regarding any payments for required services claimed by such person or institution under the Louisiana Medical Assistance Program as the State Agency may from time-to-time reasonably request.

B. The Agency Agrees:

1. To pay such facility services as indicated above in the form of vendor payments for all persons receiving required services who have been determined to be eligible for such assistance under the Louisiana Medical Assistance Program, in accordance with the existing or modified rate established by the Agency based upon the Department of Health, Education, and Welfare approved Louisiana Title XIX Cost Related Reimbursement Program for services furnished pursuant to the requirements of the Standards for Payment.

2. To make such payments in accordance with the applicable laws and by the tenth of the month following month for which the services were rendered, and a proper claim is submitted and approved.

   A penalty of not more than 1.5% per month may be charged to a patient for any account thirty days or more past due, provided that such penalty may be charged only upon that portion of the total amount for which the patient is responsible and shall not be charged on that portion of the account payable by the Provider. This is not a charge for service but a penalty for late payment of applicable income.

3. That in the event the Agency determines certain costs which have been reimbursed to Provider pursuant to this or previous agreements are not allowable, Agency shall have the right to set off and withhold said amount from amounts due the Provider under this agreement for costs that are allowed.

4. To give to Provider at least thirty (30) days' notice of any impending change in its status as a participating facility; provided, however, that Agency shall have the right to terminate this agreement immediately, if documented evidence indicates the continued operation of this agreement would jeopardize the health and welfare of medical assistance beneficiaries under the Provider's care.

5. However, should Agency terminate this agreement immediately for this reason, Agency may continue to make payments to Provider for a period not to exceed thirty (30) days from date of termination, provided that Provider assists in an orderly plan for transfer of the affected medical assistance beneficiaries.

C. The parties hereby mutually agree:

1. That this agreement shall be performed in a manner consistent with the provisions of Title XIX of the Social Security Act and of the Standards for Payment. Any future modifications or amendments to said Act or said Standards shall likewise by binding on the parties hereto.

2. That the Agency may withhold payments in whole or in part if necessary, because of any non-compliance with the Standards for Payment required by the Agency.

   a) Upon failure of Provider to submit the completed required staffing report to Agency on established date and after Agency has notified Provider of such, vendor payment may be withheld until completed report has been received.
   b) When Agency determined that incorrect or inappropriate charge(s) have been levied by the Provider against a beneficiary or their responsible person or there has been a misapplication of patient funds, a sum not to exceed the inappropriate charge, or misapplied patient funds may be withheld until restitution has been made and documentation submitted to OS.
   c) When required staffing reports indicate unapproved nurse staffing shortage, vendor payment may be withheld until such time as staffing is brought into compliance.
   d) For failure to submit a cost report within ninety (90) days of the Provider fiscal year closing date, a penalty of 5% of the total monthly payment for each month of noncompliance may be levied. The Agency may grant an extension of the ninety (90) day time limit upon request of the Provider after having shown just cause. Penalty may be a progressive penalty of 5% for each succeeding month on non-compliance.
   e) Upon failure of Provider to secure physician's re-certification of the need for care and service of a substantial number of assistance beneficiaries as often as the Standards for Payment mandate, the vendor payment may be withheld in whole or in part until such time as compliance is achieved.
   f) Upon repeated failure of Provider to ensure that an adequate plan of care, (as defined in the Standards for Payment) for a substantial number of medical assistance beneficiaries is reviewed at least at minimum intervals, as established in the Standards of Payment, the vendor payment may be withheld in whole or in part until such time as compliance is achieved.

3. That this contract shall not be transferable or assignable.

4. That the parties further agree that any breach or violation of any provision of the contract shall make this entire contract subject to immediate cancellation.

5. That as the Agency amends, modifies or changes, in accordance with law the Standards for Payment, it shall immediately furnish the provider a copy of any such changes and that the Provider shall accept such amendment, modification or change by acknowledgement by the Provider shall become incorporated by references receipt thereof; such signed acknowledgement by the Provider shall become incorporated by references as a part of this contact, and the failure of the Provider to execute and return the acknowledgement to the Agency may, at the Agency's option, serve as sufficient justification for termination of this contract.

6. That this contract may be renewed and extended in accordance with the terms if any future certification for participation which may be made by the Agency, and such renewal or extension may be made by written notice to the Provider in the form of a letter from which the contract is to be renewed or extended; and each of such letters or renewal shall be incorporated into and become a part of this contract.
   Said amendment of the Standards for Payment shall become effective upon the date that Provider signs the acknowledgement.

7. The parties hereto mutually agree that this agreement shall be effective the _____ day of _____, 20 _____.

_____	_____
Print Name of Authorized Representative	**Title / Position of Authorized Representative**
_____	_____
Signature of Authorized Representative	**Date of Signature**

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
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PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Addendum to Provider Agreement

For

- ☐ **Skilled Nursing/Technology Dependent Care (SN/TDC) (Rate 4)**
- ☐ **Skilled Nursing/Infectious Diseases (SN/ID) (Rate 5)**
- ☐ **Nursing Facility/Neurological Rehabilitation Treatment Program (NF/NRTP)**
- ☐ **Nursing Facility/Rehabilitation Services (Rate 6)**
- ☐ **Nursing Facility/Complex Care (Rate 7)**

IN THE STATE OF LOUISIANA MEDICAID PROGRAM – TITLE XIX

This addendum is a supplement to a valid provider agreement for Nursing Facility services in the Louisiana State Medical Assistance Program (Title XIX) and provider agrees to adhere to all rules, regulations and conditions which are outlined in the aforementioned instrument.

This contract has been entered into by and between the State of Louisiana through the Louisiana Department of Health hereinafter referred to as Agency, and _____ d/b/a _____, hereinafter referred to as Provider, located at _____, Louisiana, represented by _____, Owner and/or Authorized Representative. Provider agrees to meet the specific requirements outlined as follows:

1) Reimbursements for these services shall be subject to established payment limitations, standards for participation, and standards for payment and all additional requirements for provision of services indicated above
2) The facility may have entered into a contractual agreement with the bureau to begin providing the required services
3) The facility must be licensed to provide Nursing Facility services
4) The facility must have a valid Title XIX provider agreement for provision of Nursing Facility services
5) A. For SN/ID and SN/TDC, the following applies: At the end of each 12-month period, the facility shall file a supplemental long-term facility cost report that shall be subject to audit.
   B. For NF/NRTP, the following applies: At the end of each 12-month period, the facility shall file a separate standard long-term facility cost report and/or any additional cost reporting documents as required by the Department that shall be subject to audit

IN WITNESS WHEREOF, this agreement is signed and entered into on the day below as indicated.

_____ _____

Print Name of Authorized Representative **Title / Position of Authorized Representative**

_____

Signature of Authorized Representative **Date of Signature**

Original Signatures Required – Please Do NOT Use Black Ink

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