PROVIDER REQUIREMENTS

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid program, a provider must

- Meet all of the requirements for licensure as established by state laws and rules promulgated by the Department of Health and Hospitals (DHH),
- Agree to abide by all rules, regulations, policies and procedures established by the Centers for Medicare and Medicaid Services (CMS), DHH and other state agencies if applicable, and
- Comply with all the terms and conditions for Medicaid enrollment.

Providers must not have been terminated or actively sanctioned by Medicaid, Medicare or other health-related programs in Louisiana or any other state. The agency must not have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state.

Providers must document that criminal record history checks have been obtained and that employees and the employees of subcontractors do not have a criminal record as defined in 42 CFR 441.404 (b) and La. R.S. 40:1300.51et seq. Providers are not to employ individuals who have been convicted of abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. Providers must take all reasonable steps to determine whether applicants for employment have histories indicating involvement in abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual. Failure to comply with these regulations may result in any or all of the following: recoupment, sanctions, loss of enrollment, or loss of licensure.

Providers must attend all mandated meetings and training sessions as directed by DHH and/or its designee as a condition of enrollment and continued participation as a waiver provider. A Provider Enrollment Packet must be completed for each DHH administrative region in which the agency will provide services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number for that provider type.

Providers must participate in the initial training for prior authorization (PA) and data collection and any training provided on changes in the system. Initial training is provided at no cost to the agency. Any repeat training must be paid for by the requesting agency.

Providers must have available computer equipment and software necessary to participate in PA

and data collection.

All providers must maintain a toll-free telephone line with 24-hour accessibility and manned by an answering service. This toll-free number must be given to recipients at intake or at the first meeting.

Brochures providing information on the agency's experience must include the agency's toll-free number along with the Office of Aging and Adult Service's (OAAS) toll-free information number. OAAS must approve all brochures prior to use.

Waiver services are to be provided strictly in accordance with the provisions of the approved Plan of Care. ADHC and support coordination providers are obligated to report changes to DHH that could affect the recipient's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

The recipient's support coordination agency and Adult Day Health Care (ADHC) provider must have a written working agreement that includes the following:

- Written notification of the time frames for Plan of Care planning meetings,
- Timely notification of meeting dates and times to allow for provider participation,
- Assurance that the appropriate provider representative is present at planning meetings as invited by the recipient, and
- Information on how the agency is notified when a change occurs in the Plan of Care or service delivery.

Each ADHC Waiver provider shall complete the DHH approved cost report and submit the cost report(s) to the designated DHH contractor no later than five months after the state fiscal year ends (June 30). (See Appendix A to obtain web address for additional information)

Licensure and Specific Provider Requirements

Providers must meet licensure and/or certification and other additional requirements as outlined below:

Support Coordination, Transition Intensive Support Coordination, and Transition Services
Provided by a **support coordination provider** who: • Is certified to provide support coordination services • Has signed the OAAS Performance Agreement, • Has purchased a Citrix account through the OAAS, • Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training, • Has a brochure that has been approved by OAAS, • Has submitted to the OAAS a completed OAAS' agency contact information form, and • Has enrolled as a Medicaid support coordination provider.

Adult Day Health Care
Provided by an **adult day health care (ADHC) provider** who: • Is licensed according to Louisiana Revised Statute 40:2120.47 and • Has enrolled in Medicaid as an ADHC provider. **NOTE:** Qualifications for ADHC staff are set forth in the licensing regulations found in the Louisiana Administrative Code.

Provider Responsibilities

Providers of ADHC Waiver services must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective licensing authorities and in accordance with all applicable DHH and OAAS rules and policies.

Providers shall not refuse to serve any recipient who chooses their agency, unless there is documentation to support an inability to meet the recipient's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services.

Refusal to serve a recipient must be put in writing by the provider to the support coordinator and the recipient. This written notice must provide a detailed explanation as to why the provider is unable to provide services to the recipient. Upon receipt of this written documentation, the support coordinator is to forward the notice to the OAAS regional office for approval/refusal.

Providers shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to harassment, intimidation or threats against the recipient or members of the recipient's informal network, support coordination staff or employees of DHH.

Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

If the provider proposes involuntary transfer of a recipient, discharge of a recipient or if a provider closes in accordance with licensing standards, the following steps must be taken:

- The provider shall provide written notice to the recipient, a family member and/or the responsible representative, if known, and the support coordinator at least 30 calendar days prior to the transfer or the discharge,

- Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the recipient understands,

- A copy of the written discharge/transfer notice shall be put in the recipient's record,

- When the safety or health of recipients or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge,

- The written notice shall include the following:

    - A reason for the transfer or discharge,
    - The effective date of the transfer or discharge,
    - An explanation of a recipient's right to personal and/or third party representation at all stages of the transfer or discharge process,
    - Contact information for the Advocacy Center,
    - Names of provider personnel available to assist the recipient and family in decision making and transfer arrangements,
    - The date, time and place for the discharge planning conference,
    - A statement regarding the recipient's appeal rights,
    - The name of the director, current address and telephone number of the Division of Administrative Law, and
    - A statement regarding the recipient's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include:

- Holding a transfer or discharge planning conference with the recipient, family, support coordinator, legal representative and advocate, if such is known,
- Developing discharge options that will provide reasonable assurance that the recipient will be transferred or discharged to a setting that can be expected to meet his/her needs,
- Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the recipient,
- Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

Support Coordination Providers

Support coordination providers must meet all of the requirements included in the OAAS support coordination performance agreement, the support coordination standards for participation, and any additional criteria outlined in this manual chapter.

Providers of support coordination must maintain a toll-free telephone line with 24-hour accessibility manned by an answering service. This toll-free number must be given to recipients at intake or at the first meeting with the recipient.

Providers of support coordination must have brochures that provide information about their agency's experience, including the provider's toll-free number and the Office of Aging and Adult Services' (OAAS) toll-free information number.

Providers of support coordination shall furnish information and assistance to recipients in directing and managing their services.

Support coordinators must provide the recipient's approved Plan of Care to the ADHC provider in a timely manner.

ADHC Providers

ADHC provider agencies must have written policy and procedure manuals that include but are not limited to the following:

- Training policy that includes staff orientation in safety and emergency procedures as stipulated by DHH licensing and certification rules and regulations,

- Employees must possess direct care abilities, skills and knowledge to adequately perform care and assistance as required by waiver recipients,

- Employment and personnel job descriptions, hiring practices including a policy against discrimination, employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances, staffing and staff coverage plan,

- Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal,

- Identification, notification and protection of recipient's rights both verbally and in writing in a language the recipient/family is able to understand,

- Written grievance procedures,

- Information about abuse and neglect as defined by DHH regulations and state and federal laws, and

- Policies and procedures for the management of involuntary discharges/transfers from their agency.

ADHC providers must provide the recipient's approved individualized service plan to the support coordinator in a timely manner.

The ADHC provider's responsibilities related to the management of involuntary transfer/discharge include:

- Submission of a written report to the individual's support coordinator detailing the circumstances leading up to the decision for an involuntary transfer/discharge,

- Provision of documentation of efforts to resolve issues encountered in the provision of services,

- Documentation of team conferences that reflect a person-centered process conducted with the recipient, guardian or responsible representative,

- Notification of and coordination with the support coordinator to update the Plan of Care, and

- Written notification to the recipient or responsible representative at least 15 calendar days prior to the transfer or discharge that shall include:

    - The proposed date of transfer/discharge,
    - The reason for the action,
    - The names of personnel available to assist the recipient throughout the process, and
    - Information on how to request an appeal of the decision via the direct service provider's grievance policy and procedures and/or via the Division of Administrative Law. (See Appendix A for contact information)

An ADHC Waiver recipient must attend the ADHC center a minimum of 36 days per calendar quarter, absent extenuating circumstances. An AHDC provider is not allowed to impose that recipients attend a minimum number of days per week. A recipient's repeated failure to attend as specified in the Plan of Care may warrant a revision to the plan or possibly a discharge from the waiver. ADHC providers should notify the recipient's support coordinator when a recipient routinely fails to attend the center as specified.

When an ADHC provider reaches licensed capacity, the OAAS regional office should be notified immediately. The provider's name will be removed from the ADHC FOC form until they notify the OAAS regional office that they are able to admit new recipients.

An ADHC provider shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the center's responsibilities are carried out and that the following functions are adequately performed:

- Administrative,
- Fiscal,
- Clerical,
- Housekeeping, maintenance and food service,
- Direct services,
- Supervision,
- Record-keeping and reporting,

- Social services, and
- Ancillary services.

The ADHC provider shall ensure the following:

- All non-licensed direct care staff members meet the minimum, mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179-2179.1.
- All staff members are properly certified and/or licensed as legally required,
- An adequate number of qualified direct service staff is present with recipients as necessary to ensure the health, safety and well-being of recipients,
- Procedures are established to assure adequate communication among staff in order to provide continuity of services to recipients to include:
    - Regular review of individual and aggregate problems of recipients, including actions taken to resolve these problems,
    - Sharing daily information, noting unusual circumstances and other information requiring continued action by staff, and
    - Maintenance of all accidents, injuries and incident records related to recipients.
- Employees working with recipients have access to information from case records necessary for effective performance of the employees' assigned tasks,
- A staff member who has knowledge of and can apply first aid and who is certified in CPR must be in the center at all times,
- A staff member shall be designated to supervise the center in the absence of the director,
- A written plan of emergency and safety procedures that includes training staff on their duties when responding to emergencies and evacuating recipients to safe or sheltered areas,
- All furnishings and equipment must be
    - Kept clean,

- In good repair, and
- Appropriate for use by the recipients in terms of comfort and safety.

Changes

Changes in the following areas are to be reported to Health Standards Section (HSS), OAAS and the Fiscal Intermediary's Provider Enrollment Section in writing at least 10 days prior to any change:

- Ownership,
- Physical location,
- Mailing address,
- Telephone number, and
- Account information affecting electronic funds transfer (EFT).

The provider must complete a new provider enrollment packet when a change in ownership of 5 percent to 50 percent of the controlling interest occurs, but may continue serving recipients. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the agency shall not continue serving recipients until the re-certification process is complete.

When a provider agency closes or decides to no longer participate in the Medicaid program, the agency must provide a 30-day written advance notice to recipients and their responsible representatives, support coordination agencies and DHH prior to discontinuing service.