PROVIDER REQUIREMENTS

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

1. Meet all of the requirements, including licensure, as established by state laws and rules promulgated by the Louisiana Department of Health (LDH);

2. Agree to abide by all rules, regulations, policies, and procedures established by the Centers for Medicare and Medicaid Services (CMS), LDH, and other state agencies, if applicable; and

3. Comply with all of the terms and conditions for Medicaid enrollment.

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website. Section 1.1 - Provider Requirements contains detailed information concerning topics relative to Medicaid provider enrollment. (http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf)

Providers must not:

1. Have been terminated or actively sanctioned by Medicaid, Medicare or any other health-related programs in Louisiana or any other state; and

2. Have an outstanding Medicaid program audit exception or other unresolved financial liability owed to the state.

Providers are required to:

1. Complete a criminal history and background check for all potential new employees, including supervisors;

2. Retain the results of the criminal history and background checks as documentation;

3. Not hire individuals that have criminal convictions preventing employment that are listed under 42 CFR 441.404(b) and listed in La. R.S. 40:1203.1 et seq.;

4. Complete the following database checks for potential new employees, upon hire, and for current employees, on a monthly basis:

    a. Louisiana State Adverse Actions List Search; and

b. Office of Inspector General (OIG) List of Excluded Individuals.

5. Retain the results of the database checks' print outs/documents as proof that the search was conducted; and

   NOTE: Regardless of the search results, the providers MUST keep the documentation that the search was conducted.

6. Not hire the individual as an employee or allow the employee to continue working for you, if their name appears on one of the database searches/lists.

   NOTE: For instructions and details on the database checks, please see Appendix G – Database Checks.

Failure to comply with all regulations may result in any or all of the following:

1. Recoupment;
2. Sanctions;
3. Loss of enrollment; and/or
4. Loss of licensure.

Providers and support coordination agencies must attend all mandated meetings and training sessions as directed by LDH and/or its designee as a condition of enrollment/certification and continued participation as a waiver provider or support coordination agency.

A Provider Enrollment packet must be completed by the provider for each provider type and for each LDH administrative region in which the provider/agency will deliver 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.

Personal Assistance Services (PAS), Adult Day Health Care (ADHC), and caregiver temporary support services providers and support coordination agencies (except for respite centers, nursing facilities, and adult residential care providers) must:

1. Participate in all training for prior authorization (PA) and data collection. Initial training is provided at no cost to the provider. Any repeat training must be paid for by the requesting provider; and

2. Have available computer equipment software, and internet connectivity necessary to participate in PA, data collection, and Electronic Visit Verification (EVV).

All other providers must participate in the initial training for PAs and data collection and any training provided on changes in the system.

All brochures provided by the ADHC provider and support coordination agencies must be approved by the Office of Aging and Adult Services (OAAS) prior to use.

Waiver services are to be provided strictly in accordance with the provisions of the waiver beneficiary's approved plan of care (POC). All providers and support coordination agencies are obligated to immediately report to LDH any changes that could affect the waiver beneficiary's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

If the beneficiary is receiving ADHC services, the beneficiary's support coordination agency and ADHC provider must have a written working agreement that includes the following:

1. Written notification of the time frames for POC planning meetings;

2. Timely notification of meeting dates and times to allow for provider participation;

3. Assurance that the appropriate provider representative is present at planning meetings as invited by the beneficiary; and

4. Information on how the agency is notified when a change occurs in the POC or service delivery.

Support coordination agencies and PAS providers are responsible for reporting critical incidents. For additional details regarding reporting requirements, procedures, and timelines see Appendix B for the link to the *OAAS Critical Incident Reporting Manual*.

ADHC providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety, and welfare of the beneficiary and completing an incident report. The incident report shall be submitted to the beneficiary's support coordinator with the specified requirements and timelines. (See Appendix B for the link to the *OAAS Critical Incident Manual*).

Each ADHC provider must complete the LDH approved cost report and submit the cost report(s) to the designated LDH contractor on or before September 30th following the close of the cost reporting period, which is July 1st – June 30th. (See Appendix A to obtain web address for additional information).

All other CCW providers and support coordination agencies must complete the LDH approved

cost report and submit the cost report(s) to the designated LDH contractor on or before November 30th following the close of the cost reporting period, which is July 1st – June 30th. (See Appendix A to obtain web address for additional information).

Licensure and Specific Provider/Agency Requirements

Providers and agencies, must meet licensure and/or certification and other additional requirements as outlined in the tables below and in other sections of this section:

Support Coordination, Transition Intensive Support Coordination, Assistive Technology, and Transition Services
Provided by a **support coordination agency** that: 1. Is certified by LDH/OAAS to provide support coordination services; 2. Has signed the OAAS Performance Agreement; 3. Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training; 4. Has a brochure that has been approved by OAAS; 5. Has submitted a completed OAAS agency contact information form to OAAS; 6. Has enrolled as a Medicaid provider of support coordination services in all regions in which it intends to provide service; and 7. Is listed on the Support Coordination Agency FOC form.

Environmental Accessibility Adaptation (EAA)
An EAA **assessor** must have, either through their own attainments or by contracting with other professionals: 1. Clinical expertise - licensed clinical personnel (i.e. physical therapist, occupational therapist, rehabilitation engineer, etc.); **AND** 2. Construction expertise - meet the requirements of EAA contractor (described below); **AND** **3.** Specialized certification – either the clinical or construction expert must have a specialized certification in Home Modification. Specialized certification in Home Modification may consist of a supplemental certification through a licensed clinical professional's respective board, or, for the contractor, a comparable certification. **NOTE: Examples of acceptable certifications include, but are not limited to: Certified Aging in Place Specialist (CAPS), Executive Certificate in Home Modifications, Certified**

Environmental Accessibility Adaptation (EAA)

Environmental Access Consultant (C.E.A.C).

EAA assessors must submit their enrollment packet to OAAS with documentation as specified in the Medicaid Provider Enrollment packet. (See Checklist in EAA Provider Enrollment packet).

OAAS will review entire packet and issue a letter of approval - provided that all requirements are met and documentation submitted. Once all requirements have been met, OAAS will forward the packet to Medicaid Provider Enrollment.

EAA Contractor Requirements

An EAA **Contractor** (**referred to as "EAA provider"**) must:

1. Have a general contractor, home improvement, or residential building license;

OR

2. Be a currently enrolled Louisiana Medicaid durable medical equipment (DME) provider with documentation from the manufacturing company (on that company's letterhead) confirming the DME provider is an authorized distributor of a specific product that attaches to a building, and this provider has been trained on its installation;

AND

3. Meet all state and/or local requirements (such as building contractors, plumbers, electricians, or engineers).

NOTE: It is NOT permissible to be enrolled as both an EAA assessor and as an EAA provider. EAA providers shall not perform modifications beyond the scope of their state license or manufacturer authorization.

Both EAA assessors and EAA providers must:

1. Obtain enrollment as either a Medicaid EAA assessor **or** provider;
2. Be listed as a provider of choice on the FOC form;
3. Comply with LDH rules and regulations; and
4. File claims in accordance with established Medicaid guidelines.

Personal Assistance Services

Provided by a **home health provider** that:

1. Is licensed to provide home health services;
2. Ensures their direct service workers (DSWs) meet Louisiana's minimum licensing standards as a qualified home health aide for home health agencies; and
3. Has enrolled in Medicaid to provide CCW PAS.

OR

Provided by a **personal care attendant (waiver) provider** that:

1. Has an HCBS provider license with the PCA module; and
2. Has enrolled in Medicaid as a PCA (waiver) service provider.

ADHC

Provided by an **ADHC provider** that:

1. Is licensed by the LDH Health Standards Section (HSS) as an ADHC provider in accordance with Louisiana Revised Statute 40:2120.47;
2. Has enrolled in Medicaid as an ADHC provider; and
3. Is listed on the ADHC FOC form.

NOTE: Qualifications for ADHC staff are set forth in the licensing regulations found in the Louisiana Administrative Code.

Caregiver Temporary Support Services

Provided by a **personal care attendant (waiver) provider** that:

1. Has an HCBS provider license with the PCA module; and
2. Has enrolled in Medicaid to provide caregiver temporary support services under the CCW.

OR

By a **home health provider** that:

1. Is licensed to provide home health services;
2. Is Medicare certified; and
3. Has enrolled in Medicaid as a caregiver temporary support provider.

OR

By a **respite center provider** that:

1. Is licensed according to Louisiana Revised Statute 40:2101.1; and
2. Has enrolled in Medicaid as a caregiver temporary support provider.

OR

Caregiver Temporary Support Services
By an **ADHC provider** that: 1. Is licensed as an ADHC provider according to Louisiana Revised Statutes 40:2120.41-2120.47; and 2. Has enrolled in Medicaid as a caregiver temporary support provider. **OR** By a **nursing facility provider** that: 1. Is licensed as a nursing home according to Louisiana Revised Statute 40:2009.1; and 2. Has enrolled in Medicaid as a caregiver temporary support provider. **OR** By an **adult residential care provider** that: 1. Is licensed according to Louisiana Revised Statute 40:2166.1; and 2. Has enrolled in Medicaid as a caregiver temporary support provider.

Assistive Devices and Medical Supplies
Provided by an assistive devices provider that: 1. Has enrolled in Medicaid as an OAAS Waivers – assistive devices provider (provider type 17). **OR** Provided by a **DME provider** that: 1. Is enrolled to provide DME; and 2. Has enrolled in Medicaid as an OAAS Waivers - assistive devices provider (provider type 17); **OR** Provided by a **home health agency provider** that: 1. Is licensed to provide home health services; 2. Is Medicare certified; and 3. Has enrolled in Medicaid as an OAAS Waivers - assistive devices provider (provider type 17). **OR** Provided by a **PERS** provider that: 1. Has enrolled in Medicaid as a PERS provider (provider type 16); and 2. Has furnished verification (copy of letter from the manufacturer written on the manufacturer's letterhead stationary) that the provider is an authorized dealer, supplier or manufacturer of a PERS product.

Assistive Devices and Medical Supplies
OR Provided by a **support coordination agency** that: 1. Is certified by LDH/OAAS to provide support coordination services; 2. Has signed the OAAS Performance Agreement; 3. Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training; 4. Has a brochure that has been approved by OAAS; 5. Has submitted a completed OAAS agency contact information form to OAAS; 6. Has enrolled as a Medicaid provider of support coordination services in all regions in which it intends to provide service; and 7. Is listed on the support coordination agency FOC form.

Home Delivered Meals, Medically Tailored Meals and Nutritional Counseling
Provided by a **home delivered meal provider** that: 1. Is enrolled in Medicaid as a home delivered meals provider; and 2. **For in-state providers, including their subcontractors** - Has met all Louisiana Office of Public Health's (OPH's) certification permits and inspection requirements for retail food preparation, processing, packaging, storage, and distribution; **OR** 3. **For out-of-state providers** - Has met all of the United States Department of Agriculture (USDA) food preparation, processing, packaging, storage, and out-of-state distribution requirements. Permits and licenses must be issued by the state in operation.

Nursing
Provided by a **home health provider** that: 1. Is licensed to provide home health services; 2. Is Medicare certified; and 3. Has indicated a subspecialty inclusive of nursing when enrolled in Medicaid to provide CCW nursing services.

Skilled Maintenance Therapy – Physical Therapy, Occupational Therapy, or Speech/Language Therapy

Provided by a **home health provider** that:

1. Is licensed to provide home health services;
2. Is Medicare certified;
3. Has indicated subspecialties inclusive of physical therapy, occupational therapy and/or speech/language when enrolled in Medicaid to provide CCW skilled maintenance therapy services; and
4. Uses licensed therapists who have one full year of verifiable experience of working with the elderly.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

Provided by a **permanent supportive housing service provider** that:

1. Agrees to serve any OAAS waiver beneficiary who qualifies for permanent supportive housing services;
2. Is under contract and enrolled with LDH's Statewide Management Organization for Behavioral Services;
3. Has enrolled in Medicaid to provide CCW housing transition or crisis intervention services; and
4. Ensures that all agency employees who provide services have either completed the permanent supportive housing training provided by the state of Louisiana Permanent Supportive Housing program or has at least a year of experience in the Permanent Supportive Housing program as verified by the director of the Permanent Supportive Housing program prior to providing services to waiver beneficiaries.

Monitored In-Home Caregiving Services (MIHC)

Provided by a **MIHC services provider** that:

1. Has a HCBS provider license with the MIHC Module;
2. Is approved by OAAS to provide MIHC services; and
3. Has enrolled in Medicaid to provide MIHC services.

Financial Management Services

Provided by a **FMS provider** that:

1. Completes the LDH's readiness review process and receives signed approval from BHSF to move forward with provider enrollment;
2. Meets BHSF/OAAS insurance requirements; and
3. Has enrolled in Medicaid as a Financial Management Services provider.

Organized Health Care Delivery System (OHCDS)
Provided by an **OHCDS provider** that: 1. Is a qualified and enrolled Medicaid provider who directly renders at least one of the following services offered in the CCW: PAS, home delivered meals, skilled maintenance therapy, nursing, care giver temporary support services, assistive devices and medical supplies, environmental accessibility adaptations, or ADHC; 2. Shows the ability (either through its own employees or contracts with other qualified providers) to provide the above listed waiver services; Contracting with ADHC is required only if there is an ADHC provider in the service area; 3. Has signed the OAAS Organized Health Care Delivery System Provider Agreement; and 4. Has enrolled in Medicaid as an organized health care delivery system provider.

Provider Responsibilities

CCW providers 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 LDH and OAAS rules and policies.

Providers must not refuse to serve any beneficiary who chooses their agency, unless there is documentation to support an inability to meet the beneficiary'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 beneficiary must be put in writing by the provider to the support coordinator and the beneficiary. This written notice must provide a detailed explanation as to why the provider is unable to provide services to the beneficiary. Upon receipt of this written documentation, the support coordinator is to forward the notice to the Office of Aging and Adult Services Regional Office (OAAS RO) 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 beneficiary or members of the beneficiary's informal network, support coordination agency staff or employees of LDH.

Providers must 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 beneficiary, discharge of a beneficiary or if a provider closes in accordance with licensing standards, the following steps must be taken:

1. Provider shall give written notice to the beneficiary, 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;

2. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the beneficiary understands;

3. Copy of the written discharge/transfer notice shall be put in the beneficiary's record; and

4. When the safety or health of beneficiaries or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge:

    a. Written notice shall include the following:

        i. Reason for the transfer or discharge;

        ii. Effective date of the transfer or discharge;

        iii. Explanation of a beneficiary's right to personal and/or third party representation at all stages of the transfer or discharge process;

        iv. Contact information for the Advocacy Center;

        v. Names of provider personnel available to assist the beneficiary and family in decision making and transfer arrangements;

        vi. Date, time, and place for the discharge planning conference;

        vii. Statement regarding the beneficiary's appeal rights;

        viii. Name of the director, current address, and telephone number of the Division of Administrative Law; and

        ix. Statement regarding the beneficiary'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 the following:

1. Developing a written report detailing the circumstances leading to any discharge;

2. Holding a transfer or discharge planning conference with the beneficiary, family, support coordinator, legal representative, and advocate, if such is known;

3. Developing a discharge plan that specifies the beneficiary's needed supports and resources available to them after discharge and includes options that will provide reasonable assurance that the beneficiary will be transferred or discharge to a setting that can be expected to meet their needs;

4. 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 up until the transfer or discharge; and

5. Coordinating and consulting with the receiving ADHC provider or other program (if applicable) to discuss the beneficiary's needs as warranted.

If the beneficiary is transferring or discharging from ADHC services, additional transfer or discharge responsibilities for the ADHC provider shall include the following:

1. Preparing and submitting to the receiving ADHC center or program an updated discharge service plan and written discharge summary of the beneficiary's needs and health that shall include, at a minimum:

    a. Medical diagnoses;

    b. Medication and treatment history/regimen (current physician's orders);

    c. Functional needs (inabilities);

    d. Any special equipment utilized (dentures, ambulatory aids, eyeglasses, etc.);

    e. Social data and needs;

    f. Financial resources; and

    g. Any other information which would enable the receiving ADHC center/caregiver(s) to provide the continued necessary care without interruption.

Support Coordination Agencies

Support coordination agencies must do the following:

1. Meet all of the requirements included in the OAAS support coordination performance agreement, the OAAS Home and Community-Based Services (HCBS) Waivers Support Coordination Standards for Participation rule and comply with all LDH and OAAS policies and procedures;

2. Maintain a toll-free telephone line with 24-hour accessibility manned by an answering service. This toll-free number must be given to beneficiaries at intake or at the first meeting with the beneficiary;

3. Maintain OAAS approved current brochures that provide information about the agency's experience providing support coordination services and includes the following information:;

    a. That each participant has the FOC to choose their providers which does not affect eligibility for services;

    b. That a participant may contact the OAAS Help Line for information or questions regarding OAAS programs;

    c. Phone numbers for the OAAS Help Line phone number;

    d. Phone number(s) for the applicable OAAS ROs;

    e. The LDH HSS complaint line for submitting complaints against Support Coordinators, Support Coordination Agencies and Direct Service Providers (DSPs); and

    f. The agency's description, service(s) provided, current address and their local and toll-free number.

4. Complete timely revisions to the brochure, as requested by OAAS to reflect program changes and any other revisions deemed necessary by OAAS;

5. Provide adequate supplies of the agency's OAAS approved current brochures to OAAS or its designee;

6. Ensure staff attends all training mandated by OAAS;

7. Adhere to all National Voter Registration Act (NVRA) requirements. (Refer to the NVRA Manual – the link to this manual is located in Appendix B);

8. Furnish information and assistance to beneficiaries in directing and managing their services; and

9. Provide the beneficiary's approved POC to the providers in a timely manner.

If a beneficiary elects the option to self-direct their PAS, it is the support coordinator's responsibility to review the "OAAS-CCW Self-Direction Employer Handbook" with the beneficiary and be available for on-going support and assistance in these decision-making areas and with employer responsibilities.

For additional details on support coordination agency responsibilities, procedures, and timelines, refer to Appendix B for the hyperlink to the "OAAS Waiver Procedures Manual for Regional Offices and Support Coordination Agencies".

Environmental Accessibility Adaptation Providers

Providers are required to ensure that all modifications, adaptations, additions or repairs are made in accordance with all of the local and state housing and building codes, and must meet the Americans with Disabilities Act requirements.

There are 2 types of EAA providers:

1. **EAA Assessors** are responsible for the initial Home Assessment Evaluation (HAE), final inspection, and interim inspections (if needed); and

2. **EAA Contractors** (referred to as **EAA providers**) are responsible for completing actual construction and/or structural modification(s) based on the specifications provided by the EAA assessor.

EAA Assessor

Upon referral from the support coordinator, the applicable professional(s) on staff or under contract must conduct a thorough assessment of the waiver beneficiary's functional needs and environment to do the following:

1. Identify (if applicable) any DME or assistive device/technology that could meet the beneficiary's needs;

2. Determine whether or not there is a need for structural modification/environmental adaptation to the home; and

3. Complete a written HAE report to include the following:

   a. Detailed description of the findings;

   b. Recommendations to satisfy the identified needs of the beneficiary;

   c. Justification for any construction/structural modification recommendations rather than alternatives such as DME, assistive technology , etc.;

   d. Specifications for any recommended construction/structural modifications;

   e. Cost estimates for each type of recommendation; and

   f. Signatures of each member of the EAA assessor's team (staff/contractors, etc.) who participated in the evaluation.

In addition, the EAA assessor will be required to do the following:

1. Perform inspections as needed throughout the process; and

2. Perform a final inspection to ensure that all specifications have been met.

EAA Providers

Upon selection by the beneficiary, the EAA provider shall do the following:

1. Review the written HAE report submitted by the EAA assessor;

2. Provide a written bid based on specifications in the EAA assessor's report. The bid must include actual cost with labor and materials listed separately;

3. Complete the adaptation in accordance with the signed agreement/contract;

   NOTE: If, for any reason before or during the process, the EAA provider believes it necessary to deviate from the specifications provided in the EAA assessor's written report, the EAA provider must first contact the EAA assessor and request a change to the Assessor's HAE report and specifications before proceeding. The EAA assessor may exercise discretion in approving such requests.

4. Offer warranty on the service and/or product; and

5. Assume responsibility for the costs associated with bringing the work up to standard, including but not limited to materials, labor and costs of any subsequent inspections should the work not be completed according to specifications.

Personal Assistance Service Providers

A home health agency's DSW who renders PAS must be a qualified home health aide as specified in Louisiana's *Minimum Standards for Home Health Agencies* licensing regulations.

When permissible, family members who provide PAS must meet the same standards for employment as caregivers who are unrelated to the beneficiary. (See PAS Service Exclusions in Section 7.1).

Every PAS provider shall ensure that each beneficiary who receives service from their agency has a written back-up staffing plan in the event the assigned worker is unable to provide support due to unplanned circumstances or emergencies which may arise during that direct support worker's shift. If the provider cannot meet the beneficiary's needs, the provider must submit "good cause" reasons to the OAAS RO.

In all instances when a direct support worker is unable to provide support due to unplanned circumstances, including emergencies which arise during a direct support worker's shift, the direct support worker must contact the provider and family/beneficiary immediately. Actions shall then be taken according to the beneficiary's "Back-Up Staffing Plan". (See Appendix B for the link to a copy of this form).

Back-Up Staffing Plan

PAS providers must do the following:

1. Discuss available options for back-up coverage and complete the "Back-Up Staffing Plan" with the beneficiary or responsible representative;

2. Obtain all names, telephone numbers of contacts and signatures/verbal agreement of any family/natural supports responsible for emergency coverage;

3. Sign and date the form;

4. Submit the form to the beneficiary's support coordination agency within 5 business

days of being selected as the PAS provider;

NOTE: If the support coordination agency does not receive this form within 5 business days, the beneficiary will be instructed to select another provider.

5. Assess on an ongoing basis whether the "Back-Up Staffing Plan" is current and being followed according to plan; and

6. Collaborate with the beneficiary or responsible representative, support coordinator, OAAS RO and protective services when applicable, to assure that all back-up staffing difficulties are resolved appropriately.

Emergency Plan

Support coordination agencies must complete the "Emergency Plan" in a timely manner for each beneficiary they serve in accordance with OAAS policy.

PAS providers must cooperate to ensure timely completion of the "OAAS Emergency Plan" for each waiver beneficiary they serve. (See Appendix B for the link to this form).

PAS providers must do the following:

1. Collaborate with the beneficiary's support coordinator as required for completion of the "Emergency Plan"; and

2. Sign and return the form to the support coordination agency within 5 business days of receipt, or give verbal agreement, indicating responsibility accepted for designated tasks on the form.

   NOTE: If the support coordination agency does not receive this form within 5 business days, the beneficiary will be instructed to select another PAS provider.

If the emergency plan is activated, the PAS provider's director bears responsibility for performance of those tasks agreed to in the plan.

Adult Day Health Care Providers

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

1. Administrative: 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;

2. Employment Qualifications: Must possess direct care abilities, skills and knowledge to adequately perform care and assistance as required by waiver beneficiaries;

3. Training: Staff orientation in safety and emergency procedures as stipulated by LDH licensing and certification rules and regulations;

4. Records: Maintenance, security, supervision, confidentiality, organization, transfer and disposal;

5. Beneficiary Rights: Identification, notification and protection of beneficiary's rights both verbally and in writing in a language the beneficiary/family is able to understand;

6. Grievances: Written grievance procedures;

7. Abuse/Neglect: Information about abuse and neglect as defined by LDH regulations and state and federal laws; reporting responsibilities;

8. Discharges: Voluntary and involuntary discharges/transfers from their center; and

9. EVV: Requirements/proper use of check in/out; acceptable editing of electronically captured services; confidentiality of log in information; and monitoring for proper use.

ADHC providers must do the following:

1. Comply with all applicable LDH rules and regulations including the use of an approved EVV system;

2. Provide transportation to any beneficiary within their licensed region in accordance with ADHC licensing standards;

   NOTE: An ADHC center may serve a beneficiary residing outside of the ADHC's licensed region; however, the ADHC center is not required to provide transportation. ADHC centers are required to offer transportation to beneficiaries within their licensed region, but no

beneficiary, irrespective of their place of origin, may be transported for longer than 1 hour on any individual trip.

3. Provide the beneficiary's approved ISP to the support coordinator in a timely manner.

ADHC providers are not allowed to impose that beneficiaries attend a minimum number of days per week. A beneficiary's repeated failure to attend as specified in the POC may warrant a POC revision, or a possible discharge from the ADHC service and/or the CCW program. ADHC providers should notify the beneficiary's support coordinator when a beneficiary routinely fails to attend the ADHC as specified.

When an ADHC provider reaches licensed capacity, the ADHC provider must notify OAAS RO immediately. The ADHC center name will be removed from the ADHC FOC form until the ADHC provider notifies OAAS RO that they are able to admit new beneficiaries.

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

1. Administrative;
2. Fiscal;
3. Clerical;
4. Housekeeping, maintenance and food service;
5. Direct services;
6. Supervision;
7. Record-keeping and reporting;
8. Social services; and
9. Ancillary services.

The ADHC provider shall ensure the following:

1. All non-licensed direct care staff members meet the minimum, mandatory qualifications and requirements for DSWs as required by R.S. 40:2179-2179.1;

2. All staff members are properly certified and/or licensed as legally required;

3. An adequate number of qualified direct service staff is present with beneficiaries as necessary to ensure the health and welfare of beneficiaries;

4. Procedures are established to assure adequate communication among staff in order to provide continuity of services to beneficiaries to include:

    a. Regular review of individual and aggregate problems of beneficiaries, including actions taken to resolve these problems;

    b. Sharing daily information, noting unusual circumstances and other information requiring continued action by staff; and

    c. Maintenance of all accidents, injuries, and incident records related to beneficiaries.

5. Employees working with beneficiaries have access to information from case records necessary for effective performance of the employees' assigned tasks;

6. A staff member who has knowledge of and can apply first aid and who is certified in CPR must be in the ADHC center at all times;

7. A staff member who is designated to supervise the ADHC center in the absence of the director;

8. A written plan of emergency and safety procedures that includes training staff on their duties when responding to emergencies and evacuating beneficiaries to safe or sheltered areas; and

9. All furnishings and equipment are:

    a. Kept clean;

    b. In good repair; and

    c. Appropriate for use by the beneficiaries in terms of comfort and safety.

Each ADHC provider shall ensure that its setting is integrated in and supports full access to the greater community including the option to seek employment in integrated settings if desired, engaging in community life, and to receive services in the community to the same degree of access

as individuals not receiving Medicaid HCBS.

Caregiver Temporary Support Services Providers

Caregiver temporary support service providers must comply with LDH rules and regulations and be listed as a provider of choice on the FOC form as a caregiver temporary support service provider prior to providing service.

Monitored In-Home Caregiving (MIHC) Service Providers

MIHC service providers must comply with LDH rules and regulations and be listed as a provider of choice on the FOC form as a MIHC service provider before being approved to provide services. MIHC service providers must:

1. Be agency providers who employ professional nursing staff and other professionals to train and support principal caregivers to perform the direct care activities performed in the home;

2. Assess and approve the home in which services will be provided;

3. Enter into contractual agreements with caregivers who they have approved and trained; and

4. Pay per diem stipends to principal caregivers.

Assistive Devices and Medical Supply Service Providers

Assistive devices providers and support coordination agencies that provide certain assistive devices/equipment and medical supplies (ADMS) must meet the following:

1. Comply with LDH rules and regulations;

2. Be enrolled in Medicaid to provide these services; and

3. Be listed as a provider of choice on the FOC form.

PERS providers must meet the following:

1. Comply with OAAS' standards for participation;

2. Be enrolled as the applicable Medicaid provider type; and

3. Be listed as a provider of choice on the FOC form.

The PERS provider must install and support PERS equipment in compliance with all of the applicable federal, state, parish, and local laws and regulations, as well as meet manufacturer's specifications, response requirements, maintenance records, and beneficiary education.

Assistive devices providers and other enrolled providers that provide telecare services under ADMS, must meet the following system requirements:

1. Be UL listed/certified or have 501(k) clearance;

2. Be web-based;

3. Be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);

4. Have beneficiary specific reporting capabilities for tracking and trending;

5. Have a professional call center for technical support based in the United States; and

6. Have on-going provision of web-based data collection for each beneficiary, as appropriate. This includes response to beneficiary self-testing, manufacturer's specific testing, self-auditing, and quality control.

Home Delivered Meal Providers

All in-state providers must meet all of the Louisiana Office of Public Health (OPH) certification, permit and inspection requirements for retail food preparation, processing, packaging, storage, and distribution.

All out-of-state providers must meet retail food preparation, processing, packaging, storage, and distribution requirements of the USDA and the state of operation.

All providers must be enrolled in Medicaid and comply with LDH rules and regulations.

Nursing Providers

Providers must be enrolled in Medicaid as a nursing provider, comply with LDH rules and regulations, and must be listed as a provider of choice on the FOC form.

Nursing services provided must be within the scope of the Louisiana Statutes governing the practice of nursing.

Nursing services may be provided by a nurse practitioner, a registered nurse (RN) or licensed practical nurse (LPN) employed by a home health agency. Providers of nursing services must also ensure that licensed nurses have received orientation on waiver services and adhere to the requirements in the *OAAS Critical Incident Reporting Manual*. (See Appendix B for the link to this manual).

Skilled Maintenance Therapy Providers

Skilled maintenance therapy services may be provided by home health agencies that employ licensed therapists and comply with LDH rules and regulations.

Providers are not required to have a doctor's order for assessments or treatment/services before this service is reimbursed through the CCW program; however, providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.

Housing Transition or Crisis Intervention Service Providers and Housing Stabilization Service Providers

Housing transition or crisis intervention services and housing stabilization services providers must be enrolled in Medicaid to provide these services, comply with LDH rules and regulations, and be listed as a provider of choice on the FOC form.

Providers of housing transition or crisis intervention services and providers of housing stabilization services must comply with the Louisiana Permanent Supportive Housing program's critical incident reporting requirements and procedures. (See Appendix B for the link to the "Permanent Supportive Housing Policies and Procedure Manual*"*).

Providers must ensure the housing assessment is current and is performed at least annually.

Providers must cooperate and work closely with the beneficiary's support coordinator to ensure all housing issues are adequately planned for and addressed.

Assistive Technology Service Providers

Assistive technology services must be provided by support coordination agencies.

The AT devices purchased for the beneficiary must meet the following requirements:

1. Have internet capability;

2. Contain security features (locking, passwords, etc.) that are compliant with the requirements of HIPAA;

3. Be either iOS or Android system based;

4. Have a minimum screen size of 10 inches;

5. Have a minimum of 32GB storage capacity; and

6. Include a shockproof full body protective cover/case and screen protector.

Financial Management Services Providers

Financial Management Services (FMS) must be certified through the completion of LDH's readiness review process and receives signed approval from BHSF to move forward with provider enrollment.

FMS providers must meet BHSF/OAAS insurance requirements and meet the standards for participation as set forth in LAC 50:XXI.Chapter 11. Subchapters A-C.

Providers must be enrolled in Medicaid as an FMS provider, comply with LDH rules and regulations, and sign a performance agreement with LDH.

Provider Changes

For ADHC providers, the following changes must be reported in writing to the HSS, OAAS and the fiscal intermediary's Provider Enrollment Section, within 5 business days of the actual change:

1. Name of the ADHC center;

2. Physical location;

3. Mailing address;

4. Contact information (i.e. telephone number, fax number, email address); and

5. Key administrative staff (e. director, program manager, social service designee, RN/ LPN, etc.).

When a change of ownership (CHOW) occurs, the ADHC provider shall notify HSS in writing within 15 calendar days prior to the effective date of the CHOW.

For all HSS licensed providers, the following changes must be reported in writing to HSS, OAAS and the fiscal intermediary's Provider Enrollment section within the time specified in the HSS licensing rule:

1. Provider's entity name ("doing business as" name);
2. Key administrative personnel;
3. Ownership;
4. Physical location;
5. Mailing address;
6. Telephone number; and
7. Account information affecting electronic funds transfer (EFT).

When a CCW provider closes or decides to no longer participate in the Medicaid program, the provider must give at least a 30 calendar day written advance notice to all beneficiaries served and their responsible representatives, support coordination agencies, and LDH (OAAS and HSS – if licensed) prior to discontinuing service.