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, including licensure, as established by state laws and rules promulgated by the Louisiana Department of Health (LDH) unless otherwise specified;,
- 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
- Comply with all of the terms and conditions for Medicaid enrollment.

Providers must not have been terminated or actively sanctioned by Medicaid, Medicare or any other health-related programs in Louisiana or any other state. The provider 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 R.S. 40:1203.1 et 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 LDH and/or its designee as a condition of enrollment and continued participation as a waiver provider. A Provider Enrollment Packet must be completed by the provider for each provider type and for each LDH administrative region in which the agency or provider 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.

Support coordination agencies and direct service providers are obligated to report any changes to LDH that could affect the waiver recipient's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

CCW providers are responsible for documenting the occurrence of incidents or accidents that affect the health and welfare of the recipient and completing an incident report. The incident report shall be submitted to the Office of Aging and Adult Services (OAAS) or its designee with the specified requirements. (See Appendix B for information on accessing the *OAAS Critical Incident Reporting Policies and Procedures* manual.)

Providers of personal assistance services (PAS), adult day health care, support coordination and caregiver temporary support (except for respite centers, nursing facilities and adult residential care providers) must:

- 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

- Have available computer equipment and software necessary to participate in prior authorization and data collection.

Waiver services are to be provided in accordance with the approved plan of care (POC).

Licensure and Specific Provider/Agency Requirements

Providers, or agencies must meet licensure and/or certification and other additional requirements as outlined in the tables below and in other sections of 7.6:

Support Coordination, Transition Intensive Support Coordination, and Transition Services
Provided by a **support coordination agency** 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 agency.

Environmental Accessibility Adaptation (EAA)

An EAA **assessor** must have, either through their own attainments or by contracting with other professionals:

- Clinical expertise - a licensed clinical personnel (i.e. Physical Therapist, Occupational Therapist, Rehabilitation Engineer, etc).

AND

- Construction expertise - meet the requirements of Environmental Accessibility Adaptation Contractor (described below).

AND

- 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 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.

Environmental Accessibility Adaptation Contractor Requirements

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

- Have a general contractor, home improvement, or residential building license

OR

Be a currently enrolled Louisiana Medicaid 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

- 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:

- Obtain enrollment as either a Medicaid Environmental Accessibility Adaptation assessor **or** provider;
- Be listed as a provider of choice on the FOC form;
- Comply with LDH rules and regulations; and
- File claims in accordance with established Medicaid guidelines.

Personal Assistance Service

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

- Is licensed to provide home health services;
- Ensures their direct service workers meet Louisiana's Minimum Licensing Standards as a qualified home health aide for home health agencies; and
- Has enrolled to provide Community Choices Waiver personal assistance services.

OR

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

- Has a Home and Community-Based Services provider license with the Personal Care Attendant Module; and
- Has enrolled as a personal care attendant (waiver) service 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.

Caregiver Temporary Support
Provided by a **personal care attendant (waiver) provider** who: • Has a Home and Community-Based Services provider license with the Personal Care Attendant Module; and • Has enrolled in Medicaid to provide caregiver temporary support services under the Community Choices Waiver. **OR** By a **home health provider** who: • Is licensed to provide home health services; • Is Medicare certified; and • Has enrolled in Medicaid as a caregiver temporary support provider. **OR** By a **respite center provider** who: • Is licensed according to Louisiana Revised Statute 40:2101.1; and • Has enrolled in Medicaid as a caregiver temporary support provider. **OR** By an **adult day health care provider** who: • Is licensed as an Adult Day Health Care provider according to Louisiana Revised Statutes 40:2120.41-2120.47; and • Has enrolled in Medicaid as a caregiver temporary support provider. **OR** By a **nursing facility provider** who: • Is licensed as a Nursing Home according to Louisiana Revised Statute 40:2009.1; and • Is enrolled in Medicaid as a caregiver temporary support provider. **OR** By an **adult residential care provider** who: • Is licensed according to Louisiana Revised Statute 40:2166.1; and Is enrolled in Medicaid as a caregiver temporary support provider.

Assistive Devices and Medical Supplies

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

- Is licensed to provide home health services;
- Is Medicare certified; and
- Has enrolled in Medicaid as an OAAS – Community Choices Wavier assistive devices provider.

For **personal emergency response systems (PERS),** these services are provided by a provider who:

- Has enrolled in Medicaid as a PERS provider; and
- 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.

Home Delivered Meals

Provided by a **home delivered meal provider** who:

- Is enrolled in Medicaid as a home delivered meals provider; and
  - **For in-state providers, including their subcontractors** - Has met all Louisiana Office of Public Health's certification permits and inspection requirements for retail food preparation, processing, packaging, storage and distribution;
  - **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.

Nursing

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

- Is licensed to provide home health services;
- Is Medicare certified; and
- Has indicated a subspecialty inclusive of nursing when enrolled in Medicaid to provide Community Choices Waiver nursing services.

Skilled Maintenance Therapy – Physical Therapy, Occupational Therapy, or Speech/Language Therapy
Provided by a **home health provider** who: • Is licensed to provide home health services; • Is Medicare certified; • Has indicated subspecialties inclusive of physical therapy, occupational therapy and/or speech/language when enrolled in Medicaid to provide Community Choices Waiver skilled maintenance therapy services, and • 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** who: • Agrees to serve any OAAS waiver recipient who qualifies for permanent supportive housing services; • Is under contract and enrolled with LDH's Statewide Management Organization for Behavioral Services; • Has enrolled in Medicaid to provide Community Choices Waiver housing transition or crisis intervention services; and • 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 recipients.

Monitored In-Home Caregiving Services
Provided by a **monitored in-home caregiving services provider** who: • Has a Home and Community-Based Services provider license with the Monitored In-Home Caregiving Module • Is approved by OAAS to provide monitored in-home caregiving services; and • Has enrolled in Medicaid to provide monitored in-home caregiving services.

Organized Health Care Delivery System
Provided by an **organized health care delivery system provider** who: • Is a qualified and enrolled Medicaid provider who directly renders at least one service offered in the Community Choices Waiver; • Shows the ability to provide all of the services (through either its own employees or through contracts with other qualified providers) available in the Community Choices Waiver as of December 1, 2012, with the exception of support coordination, transition intensive support coordination, transition services, assistive technology and medical supplies, environmental accessibility adaptations and adult day health care if there is no licensed provider in the service area; • Has signed the OAAS Organized Health Care Delivery System Provider Agreement; and • Has enrolled in Medicaid as an organized health care delivery system provider.

Provider Responsibilities

Providers of CCW 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 LDH 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 LDH.

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 discharge 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 and

- 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 Agencies

Support coordination agencies must meet all of the requirements included in the OAAS support coordination performance agreement, the support coordination standards for participation, the CCW 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.

If a recipient elects the option to self-direct his/her PAS, it is the support coordinator's responsibility to review the *Self-Direction Employer Handbook* with the recipient and be available for on-going support and assistance in these decision-making areas and with employer responsibilities.

Environmental Accessibility Adaptation (EAA) Providers

There are two (2) types of EAA providers:

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

- **EAA Contractors** (referred to as EAA **providers**) - 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 recipient's functional needs and environment to:
- identify (if applicable) any DME or Assistive Device/Technology that could meet the recipient's needs;
- determine whether or not there is a need for structural modification/environmental adaptation to the home;
- complete a written HAE report to include:
    - a detailed description of the findings
      recommendations to satisfy the identified needs of the recipient;
    - justification for any construction/structural modification recommendations rather than alternatives such as Durable Medical Equipment (DME), Assistive Technology (AT), etc.;
    - specifications for any recommended construction/structural modifications;
    - cost estimates for each type of recommendation; and
    - 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:

- perform inspections as needed throughout the process, and
- Perform a final inspection to ensure that all specifications have been met.

EAA Providers

Upon selection by the recipient, the EAA provider shall:

- Review the written HAE report submitted by the EAA assessor
- 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.

- 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.

- Offer warranty on the service and/or product.

- 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

Every personal assistance service (PAS) provider shall ensure that each recipient 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.

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/recipient immediately. Actions shall then be taken according to the recipient's "Back-Up Staffing Plan

The following individuals are prohibited from being reimbursed for providing services to a recipient:

- The recipient's spouse;

- The recipient's curator;

- The recipient's tutor;

- The recipient's legal guardian;

- The recipient's responsible representative; or

- The person to whom the recipient has given representative and mandate authority

(also known as power of attorney).

Unless an exception is made by the OAAS, recipients are not permitted to receive personal assistance service while living in a home or property owned, operated, or controlled by a provider of services who is not related by blood or marriage to the recipient (see the link to "Who Can Be A Direct Support Worker (DSW) for PAS & LT-PCS?" in Appendix B).

Family members who provide personal assistance services must meet the same standards for employment as caregivers who are unrelated to the recipient.

PAS providers shall complete and submit the LDH approved cost report(s) to the LDH designated contractor no later than five (5) months after the state fiscal year ends (June 30). (See Appendix A to obtain web address for additional information.)

Back-Up Staffing Plan

PAS providers must:

- Discuss available options for back-up coverage and complete the "Back-Up Staffing Plan" with the recipient or responsible representative. (See Appendix B for information about accessing this form.);
- Obtain all names, telephone numbers of contacts and signatures/verbal agreement of any family/natural supports responsible for emergency coverage;
- Sign and date the form;
- Submit the form to the recipient's support coordination agency within five (5) business days of being selected as the PAS provider;

  NOTE: If the support coordination agency does not receive this form within five (5) business days, the recipient will be instructed to select another provider;

- Assess on an ongoing basis whether the "Back-Up Staffing Plan" is current and being followed according to plan and
- Collaborate with the recipient or responsible representative, support coordinator, OAAS regional office 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 recipient they serve in accordance with OAAS Policy. (See Appendix B for information on accessing this form).

PAS providers must:

- Collaborate with the recipient's support coordinator as required for completion of the "Emergency Plan"; and

- Sign and return the form to the support coordination agency within five (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 five (5) business days, the recipient 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

Adult Day Health Care (ADHC) providers are 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 of Care, or a possible discharge from the ADHC service and/or the CCW. ADHC providers should notify the recipient's support coordinator when a recipient routinely fails to attend the ADHC as specified.

When an ADHC provider reaches licensed capacity, the OAAS regional office should be notified immediately. The ADHC provider's name will be removed from the ADHC FOC form until the ADHC provider notifies the OAAS regional office that they are able to admit new recipients.
Refer to the ADHC Manual 9.5- Provider Requirements for additional information
ADHC providers shall complete the LDH approved cost report and submit the cost report(s) to the LDH designated contractor no later than five (5) months after the state fiscal year ends (June 30). (See Appendix A to obtain web address for additional information.)

Caregiver Temporary Support Service, Assistive Devices and Medical Supply Service, Home Delivered Meal Providers and Monitored In-Home Caregiving

Service Providers

Refer to Section 7.1 – Covered Services for information about these services.

Skilled Maintenance Therapy and Nursing Service Providers

Providers of skilled maintenance therapy and nursing services must:

- Perform an initial evaluation to assess the recipient's need for services;
- Develop an Individualized Service Plan for the provision of skilled maintenance therapy or nursing services which must document the supports that will be provided to the recipient to meet his/her goals based on the recipient's approved Plan of Care; and
- Inform the support coordinator immediately of the provider's inability to provide staff according to the recipient's plan.

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 Policies and Procedures* manual. (See Appendix B for information on accessing this manual.)

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

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 information on accessing 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 recipient's support coordinator to ensure all housing issues are adequately planned for and addressed.

Changes

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

- Ownership;

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

NOTE: Providers who are licensed by LDH's Health Standards Section are also required to report these changes to the Health Standards Section.

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 provider shall not continue serving recipients until the re-certification process is complete.

When a provider closes or decides to no longer participate in the Medicaid program, a 30-day written advance notice must be sent to all recipients served and their responsible representatives, support coordination agencies, the Health Standards Section (if licensed by same), and the OAAS before discontinuing service.