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) unless otherwise specified,

- 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 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 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 by the provider for each provider type for which they wish to enroll. 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.

Community Choices Waiver providers are obligated to report any changes to DHH that could affect the waiver recipient's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

Community Choices Waiver 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 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.

Each Community Choices Waiver provider shall complete the DHH approved cost report and submit the cost report(s) to the Department of Health and Hospital's (DHH) designated 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 and Transition Intensive Support Coordination
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.

Environmental Accessibility Adaptation

Provided by an **environmental accessibility adaptation provider** who:

- Has a general contractor, home improvement, or residential building license
  OR
  Is 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,
- Has met all state and/or local requirements (such as building contractors, plumbers, electricians, or engineers), and
- Has enrolled as a Medicaid environmental accessibility adaptation (environmental modification) provider.

NOTE: Providers cannot enroll to provide environmental accessibility adaptation assessor/inspector/approver services if they are enrolled to perform environmental accessibility adaptations.

An **environmental accessibility adaptation assessor/inspector/approver provider** must:

- Contract with or have on staff the following professionals who have completed a minimum of 25 assessments in their particular area of service:
  - Licensed and registered occupational therapist,
  - Licensed physical therapist, and
  - Rehabilitation engineer credentialed as either an assistive technology professional or a Registered Environmental Technician all of whom have completed a minimum of 25 assessments in their particular area of service, and
- Has enrolled as a Medicaid environmental accessibility adaptation assessor/inspector approver provider.

NOTE: Providers cannot enroll to perform environmental accessibility adaptation services if they are enrolled to perform environmental accessibility adaptation assessor/inspector/approver services.

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, 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 (wavier) provider** who: • Has a Home and Community-Based Services provider license , 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**

Caregiver Temporary Support (continued)

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 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 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,
- 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** - 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 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 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.

Provider Responsibilities

Providers of Community Choices 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 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,

- 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, the Community Choices Waiver 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. When 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

Environmental Accessibility Adaptation - Assessor/Inspector/Approver Service Providers

Upon referral from the support coordinator, the applicable professional(s) on staff or under contract must assess the waiver recipient and his/her home environment to:

- Determine whether or not there is a need for environmental adaptations to the home,
- Determine the needed adaptation,
- Provide a written report and recommendation,
- Develop specifications for needed environmental adaptation(s), and
- Perform inspections as needed.

If it is determined through this assessment process that an EAA is not needed, the assessment may include other recommendations to meet the recipient's needs such as durable medical equipment, skilled maintenance therapy services and/or nursing services.

Environmental Accessibility Adaptation - Contractor Providers

Upon selection by the recipient, the EAA provider shall:

- Assess the home environment for the recommended adaptation,
- Provide a written bid including specifications and actual cost with labor and materials listed separately,
- Complete the adaptation in accordance with the signed agreement/contract, and
- Offer warranty on the service and/or product.

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 worker's shift.

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

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.

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

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 provider within five business days of being selected as the PAS provider.

  NOTE: If the support coordination provider does not receive this form within five 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.
- 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 providers 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 provider within five business days of receipt, or give verbal agreement, indicating responsibility accepted for designated tasks on the form.

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

If the Emergency Plan is activated, the 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 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.

Caregiver Temporary Support Service, Assistive Devices and Medical Supply Service, and Home Delivered Meal 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)

Changes

Changes in the following areas are to be reported to the Health Standards Section, 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 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, and the OAAS before discontinuing service.