PROVIDER REQUIREMENTS

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

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

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

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

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

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

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

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

Waiver services are to be provided strictly in accordance with the provisions of the approved Plan of Care.

The recipient's support coordination agency and direct service provider must have a written working agreement that includes the following:

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

Support Coordination Providers

Providers of support coordination must have a signed performance agreement with OAAS to provide services to waiver recipients. Support coordination agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined in this manual chapter and the Case Management Services manual chapter. Support coordination agencies will not be able to provide services to waiver recipients or continue on the Freedom of Choice List without an adequate Quality Enhancement Plan in accordance with established policy requirements.

Direct Service Providers

The ability of a direct service provider to serve a recipient must be determined on an individual basis. Providers shall not refuse to serve any individual who chooses their agency, unless there is documentation to support an inability to meet the individual'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. Such refusal to serve an individual must be put in writing by the provider.

This written notice must provide a detailed explanation as to why the provider is unable to provide services to the individual. Upon receipt of this written documentation, the support coordinator is to forward same to the OAAS regional office.

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

- Training policy that includes staff training requirements of 16 hours of orientation prior to working with a recipient that must include how to write progress notes, and annual training requirements according to the Personal Care Attendant Licensing Standards and Direct Service Worker Registry,

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

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

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

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

- Written grievance procedures,

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

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

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

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

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

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

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

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

    - The proposed date of transfer/discharge,
    - The reason for the action,
    - The names of personnel available to assist the recipient throughout the process, and
    - Information on how to request an appeal of the decision via the direct service provider's grievance policy and procedures and/or via the DHH Appeals Bureau.

Quality Enhancement Plan

Providers must develop a Quality Enhancement Plan (QEP). This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. In accordance with established guidelines, the QEP must be submitted for approval within 60 days after the training is provided by DHH. (See Appendix B for information on obtaining the Quality Enhancement Provider Handbook and associated documents)

An adequate QEP for providers is valid for a period of one year. Resubmission must be completed no less than 60 days prior to the expiration of the current QEP.

Changes

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

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

The provider must complete a new provider enrollment packet when a change in ownership of 5 percent to 50 percent of the controlling interest occurs, but may continue serving recipients.

When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the agency shall not continue serving recipients until the re-certification process is complete.

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

Home-Based Direct Service Providers

Providers must have a back-up plan for staff coverage for employees who provide direct services and do not report as scheduled. Providers must have information explaining how the agency will have staff available at the families' request during an emergency or an unexpected change in schedule.

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 or possibly a discharge from the waiver. ADHC providers should notify the recipient's support coordinator when a recipient routinely fails to attend the center as specified.

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

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

- Administrative,
- Fiscal,
- Clerical,
- Housekeeping, maintenance and food service,
- Direct services,

- Supervision,
- Record-keeping and reporting,
- Social services, and
- Ancillary services.

The center shall ensure the following:

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

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