PROVIDER REQUIREMENTS

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

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

2. Agree to abide by all rules and regulations 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 must attend all mandated meetings and training sessions as directed by the Office for Citizens with Developmental Disabilities (OCDD) or the local governing entity (LGE) as a condition of enrollment and continued participation as a waiver provider. A provider enrollment packet must be completed for each LDH 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.

Providers must participate in the initial training for prior authorization (PA) and data collection and in 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, software, and internet connectivity necessary to participate in PA, data collection, and Electronic Visit Verification.

It is the provider's responsibility to ensure that use of contractors, including independent contractors, complies with all state and federal laws, rules, and/or regulations, including those enforced by the United States Department of Labor.

All providers must maintain a toll-free telephone line with 24-hour accessibility manned by a staff person or an answering service. This toll-free number must be given to beneficiaries 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 OCDD's toll-free information number. OCDD must approve all brochures prior to use.

Providers must develop a quality improvement and self-assessment plan. 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. The first self-assessment is due six months after approval of the Quality Improvement Plan and yearly thereafter.

The Quality Improvement Plan must be submitted for approval within 60 days after the training is provided by LDH.

Providers must be certified for a period of one year. Re-certification must be completed no less than 60 days prior to the expiration of the certification period.

The agency must be excluded for participation as an entity as evidenced by an open exclusion on the Louisiana State Adverse Actions database, the Office of Inspector General's (OIG) national exclusions database, or the federal System for Award Management (SAM) database. The agency must not have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state.

Changes in the following areas are to be reported to the Office of the Secretary's Health Standards Section, OCDD, and the fiscal intermediary's Provider Enrollment Section in writing at least 10 days prior to any change:

1. Ownership;

2. Physical location;

3. Mailing address;

4. Telephone number; and

5. 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 beneficiaries. 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 beneficiaries until the re-certification process is complete.

Waiver services are to be provided only to persons who are waiver beneficiaries, and strictly in accordance with the provisions of the approved plan of care (POC).

Providers may not refuse to serve any waiver beneficiary who chooses their agency unless there is documentation to support an inability to meet the individual's health, safety 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 and include a detailed explanation as to why the provider is unable to serve the individual. Written notification must be submitted to the LGE. Providers who contract with other entities to provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver beneficiary referred to the subcontractor by the enrolled direct service provider agency.

The beneficiary's provider and support coordination agency 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. Information on how the agency is notified when there is a POC or service delivery change; and

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

The New Opportunities Waiver (NOW) services outlined below may be provided by the provider or by an agreement with other contracted agents. The actual provider of the service, whether it is the provider or a subcontracted agent, must meet the following licensure or other qualifications:

Waiver Service	Requirements	Service Provided by
Individualized and Family Support	Home and Community-Based Services Provider License (Personal Care Attendant Module)	Enrolled agency
Center Based Respite	Home and Community-Based Services Provider License (Respite Care Module)	Enrolled agency
Community Integration Development	Home and Community-Based Services Provider License (Personal Care Attendant or Supervised Independent Living Module)	Enrolled agency
Residential Habilitation – Supported Independent Living	Home and Community-Based Services Provider License (Supervised Independent Living Module)	Enrolled agency

Waiver Service	Requirements	Service Provided by
Substitute Family Care	Home and Community-Based Services Provider License (Substitute Family Care Module and approved by OCDD)	Enrolled agency
Day Habilitation	Home and Community-Based Services Provider License (Adult Day Care Module)	Enrolled agency
Monitored In-Home Caregiving (MIHC) Services	Home and Community-Based Provider License	Enrolled agency
Supported Employment	Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services or 15 hours of documented initial and annual vocational-based training plus a Home and Community-Based Services Provider License (Supported Employment Module)	Enrolled agency
Prevocational Services	Home and Community-Based Services Provider License (Adult Day Care Module with notification to Health Standards that Prevocational Services will be provided)	Enrolled agency
Environmental Accessibility Adaptations	Registered through the Louisiana State Licensing Board for Contractors as a Home Improvement Contractor. Vehicle Lifts: Licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.	Enrolled agency
Specialized Medical Equipment and Supplies	Must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.	Enrolled agency
Personal Emergency Response Systems	Must meet all applicable vendor requirements, federal, state, parish and local laws for installation.	Enrolled agency
Professional Services	Current valid Louisiana license to practice in the field of expertise	Employed or contracted by Home and Community-Based Service Provider (Personal Care Attendant Module, Supervised Independent Living Module or Home Health agency
Skilled Nursing	Home Health license	Enrolled agency

Waiver Service	Requirements	Service Provided by
Adult Companion Care	Home and Community-Based Services Provider License (PCA Module) or Monitored In Home Caregiving License	Enrolled agency
One Time Transitional Expenses		OCDD

When required by state law, the person performing the service, such as building contractors, plumbers, electricians, or engineers, must meet applicable requirements for professional licensure and modifications to the home and must meet all applicable building code standards.

Other Provider Responsibilities

Providers of NOW services are responsible for the following:

1. Ensuring an appropriate representative from the agency attends the POC planning meeting and is an active participant in the team meeting;

   NOTE: An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the beneficiary's service delivery. This person may be a program manager, case supervisor, or the executive director or designee. An unlicensed direct service worker (DSW) is not considered an appropriate representative for the POC planning meeting.

2. Communicating and working with support coordinators and other support team members to achieve the beneficiary's personal outcomes;

3. Ensuring the provider POC documents are updated as changes occur, including the beneficiary's emergency contact information and list of medications;

4. Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or timelines in the POC will not meet the beneficiary's needs, but not later than 10 days prior to the expiration of any timelines in the service plan that cannot be met;

5. An update to the provider documents should only occur as a result of a **documented** meeting with the beneficiary or authorized representative where the reason for change is indicated and all parties sign the meeting attendance record;

6. Ensuring the provider agency support team member(s) sign and date any revisions to the service plan indicating agreement with the changes to the goals, objectives or time lines;

7. Providing the support coordination agency or LDH representatives with requested written documentation including, but not limited to:

   a. Completed, signed, and dated service plan;

   b. Service logs, progress notes, and progress summaries;

   c. DSW attendance and payroll records;

   d. Written grievance or complaint filed by beneficiary/family;

   e. Critical or other incident reports involving the beneficiary; and

   f. Entrance and exit interview documentation.

8. Explaining to the beneficiary/family in his/her native language the beneficiary rights and responsibilities within the agency;

9. Assuring that beneficiaries are free to make a choice of providers without undue influence; and

10. Medicaid has established a DSW Wage floor. Provider agencies must follow these rules and pay the DSW as directed by Medicaid. The current wage floor can be found in the Louisiana Administrative Code and the OCDD will post a memo on the OCDD website (https://ldh.la.gov/index.cfm/subhome/11/n/8). Providers will be responsible for following this directive.

Support Coordination Providers

Support Coordination

Support Coordination is a service that will assist beneficiaries in gaining access to all of their needed support services, including medical, social, educational, and other services, regardless of the funding source for the services. Providers of support coordination for the NOW program must have a signed performance agreement with OCDD to provide services to waiver beneficiaries.

Support coordination agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined by the program office.

Support Coordination activities include but are not limited to the following:

1. Convening the person-centered planning team comprised of the beneficiary, beneficiary's family, direct service providers, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies needed in order to meet the beneficiary's needs and preferences;

2. On-going coordination and monitoring of supports and services included in the beneficiary's approved POC;

3. Building and implementing the supports and services as described in the POC;

4. Assisting the beneficiary to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the beneficiary in the POC;

5. Providing information to the beneficiary on potential community resources, including formal resources and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining his/her desired personal outcomes;

6. Assisting with coordinating transportation to access medical services and community resources;

7. Assisting with problem solving with the beneficiary, families, services providers, and/or LGEs;

8. Assisting the beneficiary to initiate, develop and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet their individual needs;

9. Advocating on behalf of the beneficiary to assist them in obtaining benefits, supports or services, i.e. to help establish, expand, maintain and strengthen the beneficiary's information and natural support networks. This may involve calling

and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;

10. Training and supporting the beneficiary in self-advocacy, i.e. the selection of providers and utilization of community resources to achieve and maintain his/her desired outcomes;

11. Oversight of the service providers to ensure that their beneficiary receives appropriate services and outcomes as designated in the POC;

12. Assisting the beneficiary to overcome obstacles, recognize potential opportunities and developing creative opportunities;

13. Meeting with the beneficiary in a face-to-face meetings as well as telephone contact as specified. This includes meeting them where the services take place;

14. Must report and document any incidents/complaints/abuse/neglect according to the OCDD policy and in accordance with licensure, state laws, rules, and regulations, as applicable;

15. Must arrange any necessary professional/clinical evaluations needed and ensure beneficiary choice;

16. Must identify gather and review the array of formal assessments and other documents that are relevant to the beneficiary's needs, interests, strengths, preferences, and desired personal outcomes;

17. Develop an action plan in conjunction with the beneficiary to monitor and evaluate strategies to ensure continued progress toward the beneficiary's personal outcomes; and

18. On-going discussions with the beneficiary (aged 16 years or older) about employment including identifying barriers to employment and working to overcome those barriers, connecting the beneficiary to certified work incentive coordinators (CWIC) to do benefits planning, referring the beneficiary to Louisiana Rehabilitation Services (LRS) and following the case through closure with LRS, and other activities of the employment process as identified. This includes the quarterly completion of and data input using the Path to Employment Form.

NOTE: Advocacy is defined as assuring that the beneficiary receives appropriate supports and services of high quality and locating additional services not readily available in the community.

Support Coordination Providers Qualifications

Support Coordination providers must meet the following requirements:

1. Be licensed as a support coordination provider; and

2. Meet all requirements as outlined in the *Support Coordination Performance Agreement.*

NOTE: Please refer to *the Guidelines for Support Planning, Operational Instruction for Critical Incident Review*, and *OCDD Support Coordination Reference Guide* for additional information.

Direct Service Provider Responsibilities

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

1. Training policy that includes orientation and staff training requirements according to the Home and Community-Based Service Providers Licensing Standards and the DSW Registry;

2. Direct care abilities, skills, and knowledge requirements that employees must possess to adequately perform care and assistance as required by waiver beneficiaries;

3. 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;

4. Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal;

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

6. Written grievance procedures;

7. Information about abuse and neglect as defined by LDH regulations and state and federal laws;

8. EVV: requirements/proper use of check in/out; acceptable editing of electronically captured services; reporting services when in "no service zones" or failure to clock in/out (Electronic Connectivity Form and manual entry); confidentiality of log in information; monitoring of EVV system for proper use;

   NOTE: NOW providers must use the electronic visit reverification (EVV) system designated by the Department for automated scheduling, time and attendance tracking, and billing for certain home and community-based services. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the NOW provider manual.

9. DSW Registry: requirement for accessing the department's Adverse Action database for findings placed against the DSWs prohibiting employment; and

10. Criminal History Checks: requirement for compliance with state statutes for non-licensed direct care personnel.

POC Provider Documents

The direct service provider must complete the provider portion of the POC to include all waiver services that the agency provides to the beneficiary based on the identified POC goals and other supports required.

The provider documents in the POC must be person-centered, focus on the beneficiary's desired outcomes and include the following elements:

1. Specific activities to achieve the goals outlined in the beneficiary's approved POC; and

2. Strategies or supports needed to meet the individual's needs.

The POC provider documents must be reviewed and updated as necessary to comply with the specified goals, objectives, and timelines stated in the beneficiary's approved POC or when changes are necessary based on beneficiary needs.

Providers who receive the IFS supplemental payment for supporting individuals with complex behavioral needs are responsible for preparing the Behavioral Supports (CPOC Attachment G) and the Emotional Wellness Crisis Prevention Plan (CPOC Attachment F). Providers who receive the IFS supplemental payment for supporting individuals with complex medical needs are responsible for completing the Complex Care Medical Supports (CPOC Attachment L) and any documentation required by Attachment L. Providers are also responsible for providing evidence of training by a registered nurse (RN), including written delegations for the direct care staff to perform the non-complex medical tasks. A current RN assessment is also required and is to be updated quarterly.

Back-up Planning

Direct service providers are responsible for providing all of the necessary staff to fulfill the health and welfare needs of the beneficiary when paid supports are scheduled to be provided. This includes times when the scheduled DSW is absent or unavailable or unable to work for any reason.

All direct service providers are required to develop an individualized back-up plan for each beneficiary. Direct service providers are required to have policies in place which outline the protocols the agency has established to assure that back-up DSWs are readily available, lines of communication and chain of command procedures have been established, and procedures for dissemination of the back-up plan information to beneficiaries, their authorized representatives and support coordinators. Protocols must also describe how and when the direct support staff will be trained in the care needed by the beneficiary. This training must occur prior to any direct support staff being solely responsible for a beneficiary.

Back-up plans must be updated as changes occur to assure that the information is kept current and applicable to the beneficiary's needs. The back-up plan must be submitted to the beneficiary's support coordinator in a timely manner to be included as a component of the beneficiary's initial and annual POC.

Direct service providers may not use the beneficiary's informal support system as a means of meeting the agency's individualized back-up plan and/or emergency evacuation response plan requirements without documented consent of the informal support system. The beneficiary's family members and others identified in the beneficiary's circle of support may elect to provide backup, but this does not exempt the provider from the requirement of providing the necessary staff for backup purposes when paid supports are scheduled.

Emergency Evacuation Planning

Emergency evacuation plans must be developed in addition to the beneficiary's individualized back-up plan. Providers must have an emergency evacuation plan that specifies in detail how the

direct service provider will respond to potential emergency situations such as fires, hurricanes, tropical storms, hazardous material release, flash flooding, ice storms, and terrorist attacks.

The emergency evacuation plan must be person-specific and include at a minimum the following components:

1. Individualized risk assessment of potential health emergencies;

2. A detailed plan to address the beneficiary's individualized evacuation needs, including a review of the beneficiary's individualized back-up plan, during geographical and natural disaster emergencies and all other potential emergency conditions;

3. Policies and procedures outlining the agency's implementation of emergency evacuation plans and the coordination of these plans with the local Office of Emergency Preparedness and Homeland Security;

4. Establishment of effective lines of communication and chain of command procedures;

5. Establishment of procedures for the dissemination of the emergency evacuation plan to beneficiaries and support coordinators; and

6. Protocols outlining how and when DSWs and beneficiaries will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

Training for DSWs and verification of competency must occur prior to the worker being solely responsible for the support of the beneficiary.

The beneficiary must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

OCDD, support coordination agencies, and direct service provider agencies are responsible for following the established emergency protocol before, during, and after hurricanes or other natural disasters or events as outlined in the "Emergency Protocol for Tracking Location Before, During and After Hurricanes" document found in the OCDD *Guidelines for Support Planning* manual. (See Appendix D for *Guidelines for Support Planning* information).

Residential Habilitation – Supported Independent-Living Provider Responsibilities

In addition to the approved direct support hours provided to the beneficiary, the Supported Independent Living (SIL) provider is responsible for maintaining weekly contact with the beneficiary for supervision purposes and making a minimum of one monthly face-to-face contact in the home to ensure the living situation complies with licensing requirements. The minimum requirements for SIL contacts are as follows:

1. Two contacts every week (Sunday through Saturday) with the beneficiary, either face-to-face, by phone, or through adaptive communication technology. These two weekly contacts are for supervision purposes and are intended to provide the beneficiary an opportunity to express concern and provide assurance that all needs are being met; and

2. One monthly contact (each calendar month) face-to-face with the beneficiary in the beneficiary's home. This contact is intended to ensure that the living situation is safe, that it complies with licensing requirements, and that all necessary support is provided to the beneficiary (medications are refilled, no repairs are necessary, adequate food is in home, bills are paid, staff is working the hours required, no abuse/neglect, etc.). The frequency of the face-to- face contacts shall be based on the beneficiary's needs.

The weekly supervision contacts are separate from the monthly in-home contact; therefore, the monthly in-home contact will not count as one of the two weekly contacts required. Providers may make as many contacts in a day as are necessary to meet the needs of the beneficiary. However, only one contact per day (either weekly or monthly contacts) will count towards meeting the minimum contacts required. Attempted contacts are unacceptable and will not count towards meeting any of the minimum contact requirements. Any identified payment made to a provider agency for an incomplete contact will be subject to recoupment of funds paid. All contacts used for billing purposes must be documented. The contact must identify the name of the beneficiary contacted, date of the contact, beginning and ending time of the contact, topics discussed during the contact, and the printed name and signature of the person making the contact.

Beneficiary contacts must be completed by a supervisor of the provider agency so designated due to the supervisor's experience and expertise relating to client needs or an employee of the provider agency who is a licensed/certified professional (Qualified Intellectual Disability Professional) qualified in the State of Louisiana and who meets the requirements as defined by the Title 42, Section 483.430 of the Code of Federal Regulations [42 CFR 483.430]. Providers are required to maintain appropriate documentation indicating these requirements for all required contacts.

NOTE: The billing week begins at midnight Sunday (12:00 a.m.) and ends at midnight the following Sunday (12:00 a.m.).

The provider must provide back-up staff that is available on a 24-hour basis. SIL services must be coordinated with any services listed in the approved POC.

SIL providers are responsible for assisting beneficiaries with obtaining the completed Form 90-L from their primary care physician on an annual basis.

Day Habilitation Provider Responsibilities

The service provider must possess a current valid Home and Community-Based Service Providers License to provide adult day care services and adhere to the following requirements in order to provide transportation to beneficiaries:

1. The provider's vehicles used in transporting beneficiaries must adhere to the requirements of the HCBS licensing rule;

2. Providers must maintain liability insurance in the amount specified in the HCBS licensing requirements;

3. Drivers must have a current Louisiana driver's license applicable to the vehicle being used; and

4. The provider must document this service in the provider's transportation log, which can be either electronic with GPS tracking or a paper log. The log is not required to be filed in the beneficiary's record file, but must contain information that identifies the beneficiary, the time of pick up, and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including LGEs and Support Coordination.

Supported Employment Provider Responsibilities

Supported Employment providers must maintain documentation in the file of each individual beneficiary that the services are not available to the beneficiary in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) [20 U.S.C. 1401 (26) and (29)].

The service provider must possess a current valid Home and Community-Based Service Providers License provide adult day care services to provide adult day care services and adhere to the following requirements in order to provide transportation to beneficiaries:

1. The provider's vehicles used in transporting beneficiaries must adhere to the requirements of the HCBS licensing rule;

2. Drivers must have a current Louisiana driver's license applicable to the vehicle being used; and

3. The provider must document this service in the provider's transportation log, which can be either electronic with GPS tracking or a paper log. The log is not required to be filed in the beneficiary's record file, but must contain information that identifies the beneficiary, the time of pick up and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including LGEs and Support Coordination.

Prevocational Services Provider Responsibilities

The provider must maintain documentation in the file of each individual beneficiary receiving Prevocational Services that the services are not available to eligible beneficiaries in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) [20 U.S.C. 1401 (26) and (29)].

Professional Services – Psychological Provider Responsibilities

Providers of psychological services must:

1. Perform an initial evaluation to assess the beneficiary's need for services;

2. Develop an Individualized Service Plan for the provision of psychological services, which must document the supports that will be provided to the beneficiary to meet his/her goals based on the beneficiary's approved POC;

3. Implement the beneficiary's therapy service plan in accordance with appropriate licensing and certification standards;

4. Complete progress notes for each session, within 10 calendar days of the session, and provide notes to the beneficiary's support coordinator every three months or as specified in the POC;

5. Maintain both current and past records and make them available upon request to OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS), and/or legislative auditors; and

6. Bill only for services rendered, based on the beneficiary's approved POC and PA.

Skilled Nursing Services Provider Responsibilities

Provider agencies of skilled nursing services must:

1. Ensure that all nurses employed to provide skilled nursing services are either registered nurses or licensed practical nurses who have a current Louisiana Board of Nursing license with a minimum of one year of supervised nursing experience in providing Skilled nursing services in a community setting to beneficiaries;

2. Provide an orientation on waiver services to licensed nurses and assure that licensed nurses adhere to the OCDD Critical Incident Reporting policy. (See Appendix D for information regarding this policy);

3. Collect and submit the following documents to the beneficiary's support coordination agency:

    a. Primary care physician's order for Skilled Nursing services:

        i. The physician's order must be signed and dated and must contain the number of hours per day and duration of Skilled Nursing services required to meet the beneficiary's needs. This order must be updated at least every 60 days. The physician's order must be submitted to the LGEs with the beneficiary's annual POC and upon request. PA will not be released if the physician's order is not submitted as required.

    b. Primary care physician's letter of necessity for Skilled Nursing services:

        i. The physician's letter of medical necessity must be on the physician's letterhead.

    c. Current Form 90-L signed by the beneficiary's primary care physician;

d. Summary of the beneficiary's medical history:

i. The summary must indicate the beneficiary's service needs, based on a documented record review, and specify any recent (within one year) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) extended home health service approvals.

e. CMS Form 485 completed by the home health agency to identify the Skilled Nursing service needs.

4. Develop and implement an Individual Nursing Service Plan in conjunction with the beneficiary's physician, support team, and the support coordinator to identify and fulfill the beneficiary's specific needs in a cost-effective manner;

5. Render services to the beneficiary as ordered by the beneficiary's primary care physician and as reflected in the beneficiary's POC within the requirements of the Louisiana Nurse Practice Act. For the purpose of this policy, nursing assessments, nursing care planning, and revisions of care planning must be consistent with the Outcome and Assessment Information Set (OASIS) requirements used by home health agencies that provide Skilled Nursing services;

6. Complete progress notes for each treatment, assessment, intervention, and critical incident;

7. Provide the support coordination agency with physician-ordered changes every 60 days regarding the beneficiary's health status and health needs;

8. Inform the support coordinator immediately of the providers' inability to provide staff according to the beneficiary's nursing service plan;

9. Report any beneficiary's non-compliance with or refusal of the established Individual Nursing Service Plan and provide these notes to the designated support coordinator every three months, or as specified in the POC;

10. Maintain both current and past records and make them available upon request to the OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS), and/or legislative auditors;

11. Bill for prior authorized services rendered based on the beneficiary's approved POC;

12. Ensure the home health nurse and the beneficiary's support coordinator communicate at least monthly to determine if any further planning is required;

13. Report any changes in the beneficiary's nursing service needs to the support coordinator. If necessary, the support coordinator will call an interdisciplinary team meeting to review the POC and to discuss any needed revisions. Changes to skilled nursing services, in accordance with regulations, must be reflected in the Individual Nursing Services Plan and submitted to the support coordinator every 60 days;

NOTE: It is not necessary to revise the POC every 60 days unless there is a change in the beneficiary's medical condition requiring the need for additional Skilled Nursing services or the beneficiary requests a change.

14. Changes in the Individual Nursing Service Plan must be approved by the primary care physician and reflect the physician's orders for the skilled nursing service;

15. Ensure the Individual Nursing Service Plan is current and available in the beneficiary's home at all times;

16. Follow all NOW requirements, minimum standards for home health agencies and state and federal rules and regulations for licensed home health agencies and nursing care; and

17. Comply with OCDD standards for payment, Medical Assistance Program Integrity Law (MAPIL), HIPAA, ADA, and licensing requirements.

Adult Companion Care Services Provider Responsibilities

The provider organization must develop a written agreement as part of the beneficiary's POC that defines all of the shared responsibilities between the companion and the beneficiary. The written agreement shall include, but is not limited to the following:

1. Types of support provided by the companion;

2. Activities provided by the companion; and

3. A typical weekly schedule.

Revisions to this agreement must be facilitated by the provider organization and approved by the support team. Revisions may occur at the request of the beneficiary, the companion, the provider, or other support team members.

The provider organization is responsible for performing the following functions which are included in the daily rate:

1. Arranging the delivery of services and providing emergency services;

2. Making an initial home visit to the beneficiary's home, as well as periodic home visits as required by the department;

3. Contacting the companion a minimum of once per week or as specified in the beneficiary's comprehensive POC;
4. Providing 24-hour oversight and supervision of the adult companion care services, including back-up for the scheduled and unscheduled absences of the companion; and

5. Facilitating a signed written agreement between the companion and the beneficiary that assures the following:

    a. The companion's portion of expenses must be at least $200 per month, but shall not exceed 50 percent of the combined monthly costs, which include rent, utilities, and primary telephone expenses; and

    b. Inclusion of any other expenses must be negotiated between the beneficiary and the companion. These negotiations must be facilitated by the provider, and the resulting agreement must be included in the written agreement and in the beneficiary's POC.