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 and regulations 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 attend all mandated meetings and training sessions as directed by the Office for Citizens with Developmental Disabilities (OCDD) as a condition of enrollment and continued participation as a waiver provider. Attendance at a provider enrollment orientation is required prior to enrollment as a Medicaid 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.

Providers must participate in the initial training for prior authorization 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 the necessary computer equipment and software available to participate in prior authorization 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 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 DHH.

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 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.

Changes in the following areas are to be reported to the Bureau of Health Services Financing Health Standards Section, OCDD 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.

Waiver services are to be provided only to persons who are waiver recipients, and strictly in accordance with the provisions of the approved Plan of Care.

Providers may not refuse to serve any waiver recipient that 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 OCDD regional waiver office or the Human Service Authority or District. 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 recipient referred to them by the enrolled direct service provider agency.

The recipient's provider and support coordination agency 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,
- Information on how the agency is notified when there is a Plan of Care or service delivery change, and
- Assurance that the appropriate provider representative is present at planning meetings as invited by the recipient.

The 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	Personal Care Attendant License	Enrolled agency
Center Based Respite	Respite License for a facility	Enrolled agency
Community Integration Development	Personal Care Attendant License or Supervised Independent Living License	Enrolled agency
Residential Habilitation – Supported Independent Living	Supervised Independent Living License	Enrolled agency
Substitute Family Care	Substitute Family Care License and approved by OCDD	Enrolled agency
Day Habilitation	Adult Day Care Center 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 Adult Day Care Center License to provide transportation	Enrolled agency

Employment-Related Training	Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services or 15 hours of documented initial and annual vocational-based training Adult Day Care Center License to provide transportation	Enrolled agency
Environmental Accessibility Adaptations	Registered through the Louisiana State Licensing Board for Contractors as a Home Improvement Contractor.	Enrolled agency
	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.	
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 Personal Care Attendant agency, Supported Independent Living agency or Home Health agency
Skilled Nursing	Home Health 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:

- Ensuring an appropriate representative from the agency attends the Plan of Care 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 recipient's service delivery.

This person may be a program manager, a direct service professional who works with or will work with the recipient, the executive director or designee.

- Communicating and working with support coordinators and other support team members to achieve the recipient's personal outcomes,

- Ensuring the recipient's emergency contact information and list of medications are kept current,

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

- 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,

- Providing the support coordination agency or DHH representatives with requested written documentation including, but not limited to:

    - Completed, signed and dated service plan,
    - Service logs, progress notes, and progress summaries,
    - Direct service worker attendance and payroll records,
    - Written grievance or complaint filed by recipient/family,
    - Critical or other incident reports involving the recipient, and
    - Entrance and exit interview documentation.

- Explaining to the recipient/family in his/her native language the recipient rights and responsibilities within the agency, and

- Assuring that recipients are free to make a choice of providers without undue influence.

Support Coordination Providers

Providers of support coordination for the NOW program must have a signed performance agreement with OCDD 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 the Case Management Services manual chapter.

Direct Service Provider Responsibilities

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

- Training policy that includes orientation and staff training requirements according to the Personal Care Attendant Licensing Standards and the Direct Service Worker Registry,
- Direct care abilities, skills and knowledge requirements that employees must possess 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, and
- Information about abuse and neglect as defined by DHH regulations and state and federal laws.

Individualized Service Plan

The direct service provider must develop an individualized service plan to include all waiver services that the agency provides to the recipient based on the recipient's identified Plan of Care goals.

The individualized service plan must be person-centered, focus on the recipient's desired outcomes, and include the following elements:

- Specific goals matching the goals outlined in the recipient's approved Plan of Care,
- Measurable objectives and timelines to meet the specified goals,

- Strategies to meet the objectives,
- Identification of the direct service provider staff and any other support team members who will be involved in implementing the strategies, and
- The method that will be used to document and measure the implementation of specified goals and objectives.

The individualized service plan must be reviewed and updated as necessary to comply with the specified goals, objectives, and timelines stated in the recipient's approved Plan of Care.

Back-up Planning

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

All direct service providers are required to develop a functional individualized back-up plan for each recipient that includes detailed strategies and person-specific information that addresses the specialized care and supports needed by the recipient. Direct service providers are required to have policies in place which outline the protocols the agency has established to assure that back-up direct service workers 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 recipients, 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 recipient. This training must occur prior to any direct support staff being solely responsible for a recipient.

Back-up plans must be updated at least annually to assure that the information is kept current and applicable to the recipient's needs. The back-up plan must be submitted to the recipient's support coordinator in a timely manner to be included as a component of the recipient's initial and annual Plan of Care.

Direct service providers may not use the recipient's informal support system as a means of meeting the agency's individualized back-up plan and/or emergency evacuation response plan requirements. The recipient's family members and others identified in the recipient'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.

Emergency Evacuation Planning

Emergency evacuation plans must be developed in addition to the recipient'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:

- Individualized risk assessment of potential health emergencies,
- A detailed plan to address the recipient's individualized evacuation needs, including a review of the recipient's individualized back-up plan, during geographical and natural disaster emergencies and all other potential emergency conditions,
- 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,
- Establishment of effective lines of communication and chain of command procedures,
- Establishment of procedures for the dissemination of the emergency evacuation plan to recipients and support coordinators, and
- Protocols outlining how and when direct service workers and recipients will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

Training for direct service workers must occur prior to the worker being solely responsible for the support of the recipient.

The recipient 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 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 recipient, the Supported Independent Living (SIL) provider is responsible for three documented recipient contacts per week. At least one contact must be face-to-face with the recipient, and the other two contacts may be made by telephone. Providers may make as many contacts in a day as are necessary to meet the needs of the recipient; however, only one of those contacts will be accepted as having met one of the three required contacts.

No combination of telephone contacts and the face-to-fact contact can be billed or accepted as having met more than one of the required contacts on the same date. Attempted face-to-face contacts or telephone contacts are unacceptable and will not count towards meeting the requirements. Any identified payment made to a provider agency for an incomplete contact will be subject to recoupment of funds paid.

Recipient contacts must be completed by a supervisor of the provider agency or an employee of the provider agency who is a licensed/certified 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. 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-hours basis.

SIL services must be coordinated with any services listed in the approved Plan of Care.

SIL providers are responsible for assisting recipients 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 license as an Adult Day Care Center and adhere to the following requirements in order to provide transportation to recipients:

- The provider's vehicles used in transporting recipients must:

- Be in good repair,
- Have a current Louisiana inspection sticker,
- Have a first aid kit on board, and
- Carry at least $1,000,000 liability insurance.

- Drivers must have a current Louisiana driver's license applicable to the vehicle being used, and

- The provider must document this service in the recipient's record and the trip must be documented in the provider's transportation log.

Supported Employment Provider Responsibilities

Supported Employment providers must maintain documentation in the file of each individual recipient that the services are not available to the recipient 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 (16) and (71).

The service provider must possess a current valid license as an Adult Day Care Center and adhere to the following requirements in order to provide transportation to recipients:

- The provider's vehicles used in transporting recipients must:

  - Be in good repair,
  - Have a current Louisiana inspection sticker, and
  - Have a first aid kit on board, and
  - Carry at least $1,000,000 liability insurance.

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

- The provider must document this service in the recipient's record and the trip must be documented in the provider's transportation log.

Employment Related Training Provider Responsibilities

The provider must maintain documentation in the file of each individual recipient receiving Employment-Related Training that the services are not available to eligible recipients 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 (16) and (71).

Professional Services – Psychological Provider Responsibilities

Providers of psychological services must:

- Perform an initial evaluation to assess the recipient's need for services,
- Develop an Individualized Service Plan for the provision of psychological 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,
- Implement the recipient's therapy service plan in accordance with appropriate licensing and certification standards,
- Complete progress notes for each session, within ten days of the session, and provide notes to the recipient's support coordinator every three months or as specified in the Plan of Care,
- 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
- Bill only for services rendered, based on the recipient's approved Plan of Care and prior authorization.

Skilled Nursing Services Provider Responsibilities

Provider agencies of Skilled Nursing services must:

- 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 recipients.
- 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)
- Collect and submit the following documents to the recipient's support coordination agency:
    - Primary care physician's order for Skilled Nursing services.

The physician's order must be signed, dated, and contain the number of hours per day and duration of Skilled Nursing services required to meet the recipient's needs. This order must be updated at least every 60 days. A copy of the physician's order must be sent to the support coordination agency prior to expiration of the previous approval to ensure continuation of services. The physician's order must be submitted to the OCDD regional waiver office with the recipient's annual Plan of Care. Prior authorization will not be released if the physician's order is not submitted as required.

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

  The physician's letter of necessity must be on the physician's letterhead, identify all nursing duties to be performed by the nurse, and state the recipient's current medical condition and need for Skilled Nursing services.

- Current Form 90-L signed by the recipient's primary care physician.

- Summary of the recipient's medical history.

  The summary must indicate the recipient'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 approvals.

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

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

- Render services to the recipient as ordered by the recipient's primary care physician and as reflected in the recipient's Plan of Care 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.

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

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

- Inform the support coordinator immediately of the providers' inability to provide staff according to the recipient's nursing service plan.

- Report any recipient'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 Plan of Care.

- 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.

- Bill for prior authorized services rendered based on the recipient's approved Plan of Care.

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

- Report any changes in the recipient's nursing service needs to the support coordinator. If necessary, the support coordinator will call an Interdisciplinary Team meeting to review the Plan of Care and to discuss any needed revisions. Changes which increase Skilled Nursing services in accordance with regulations, must revise the Individual Nursing Services Plan every 60 days.

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

- 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.

- Ensure the Individual Nursing Service Plan is current and available in the recipient's home at all times.

- 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.

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