PROVIDER REQUIREMENTS

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

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

PACE providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website. Section 1.1 - Provider Requirements contains detailed information concerning topics relative to Medicaid provider enrollment. (http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf)

PACE providers must attend all mandated meetings and training sessions as directed by LDH and/or its designee as a condition of enrollment and continued participation as a PACE provider. A Provider Enrollment Packet must be completed by the PACE provider.

Failure to comply with all regulations may result in any or all of the following:

- Recoupment;
- Sanctions;
- Suspension of enrollment;
- Suspension of payment; or
- Termination of the PACE program agreement.

PACE providers must not employ the following individuals or contract with organizations, providers or individuals:

- Who have been excluded from participation in the Medicare or Medicaid programs;

- Who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Act;

- If the PACE provider determines that an individual's contact with participants would pose a potential risk because the individual has been convicted of one or more criminal offenses related to physical, sexual, drug, or alcohol abuse or use;

- Who have been found guilty of abusing, neglecting, or mistreating individuals by a court of law or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property; or

- Who have been convicted of specific crimes for any offense described in section 1128(a) of the Social Security Act.

Provider Certifications/Recertification Requirements

The State Readiness Review, developed by Centers for Medicare and Medicaid Services (CMS), is used by OAAS to perform the readiness review of brand new non-operational Program of All-Inclusive Care for the Elderly (PACE) organizations. OAAS must conduct a provider readiness assessment prior to operation. OAAS reviews the PACE organization's policies and procedures, the design and construction of the building, emergency preparedness, compliance with Occupational Safety and Health Administration (OSHA), Food and Drug Administration (FDA), state and local laws and life safety codes. CMS and OAAS must conduct a site review within six (6) months of the PACE provider enrolling its first beneficiary.

CMS and OAAS must conduct comprehensive annual reviews of PACE providers during the trial review period for the first three years of operation in order to ensure compliance with the PACE requirements. Review and analysis of PACE's compliance may include but not limited to the following:

- Observation of the PACE provider program operations;

- Review of marketing;

- Review of beneficiary services;

- Review of enrollment and disenrollment; and

- Review of grievances and appeals.

After the initial three-year period, CMS and OAAS conducts reviews, including an on-site visit, at least every two (2) years.

CMS and/or OAAS send all review results to the PACE provider along with any recommendations for changes to its program. The PACE provider must write a corrective action plan (CAP) that describes the details that will be taken to correct the identified deficiency(ies). When deficiencies are found, the PACE provider must take action through the following:

- Ongoing monitoring of the PACE provider;
- Reviews and audits of the PACE provider;
- Complaints from PACE beneficiaries and/or caregivers;
- Any other instance CMS or OAAS identifies programmatic deficiencies requiring correction;
- CMS and/or OAAS must make the review results available to the public, if requested;
- Post a notice that the review results and the corrective action plan/responses are available for viewing; and
- Make the review results available for viewing in a place that is easily accessible to beneficiaries, their families, caregivers and their responsible representatives.

CMS or OAAS must monitor the effectiveness of the corrective actions. Failure to correct the deficiencies, may result in sanctions or termination for the PACE provider.

Licensure and Specific Provider Requirements

PACE providers must:

- Be enrolled in the Medicaid program as a PACE provider;
- Licensed by the Health Standards Section (HSS) as an ADHC facility; and
- Hold a Medicaid provider agreement/provider number as a PACE provider.

Exceptions to Licensure Requirements

HSS will grant the following exceptions to the ADHC licensing requirements for PACE providers:

- HSS may grant waivers of ADHC licensing requirements as appropriate and allowed;

- ADHC licensing requirement states that an ADHC center shall not admit more beneficiaries into care than the number specified on their license. PACE providers may enroll more beneficiaries into the PACE center than the ADHC license will allow but the PACE center must not exceed the licensed capacity on any day; and

- ADHC licensing requirement states that an individual who has not attended an ADHC center at least 36 days each quarter (every 3 months) shall not be eligible for ADHC services. A PACE beneficiary may have supports at his/her home during the day and may not need the daily support provided by the ADHC component of PACE. The frequency of a beneficiary's attendance at the PACE center is determined by the PACE interdisciplinary team (IDT) based on the needs and preferences of the beneficiary. Therefore, the beneficiary may not attend the center within the 36 days per quarter period and will not be disenrolled from the PACE program.

Provider Responsibilities

The PACE provider must:

- Employ or contract a program director who is responsible for oversight and administration of the entity;

- Employ or contract with a medical director who is responsible for the delivery of beneficiary care, for clinical outcomes and for the implementation, as well as oversight, of the quality improvement program;

- Have a current organizational chart showing PACE provider staff members and relationships to any other organizational entities;

- Notify CMS and OAAS in writing, at least 14 calendar days, before the change when the PACE provider is changing their organizational structure;

- Notify CMS and OAAS in writing, at least 60 calendar days before the anticipated effective date of the change when the PACE provider is planning a change of ownership;

- Be operating under the control of an identifiable governing body that includes at least 1 beneficiary or a designated individual functioning as a governing body with full legal authority and responsibility for the following:

    - Governance and operation of the organization;

    - Development of policies consistent with mission;

    - Management and provision of all services, including the management of contractors;

    - Establishment of personnel policies that address adequate notice of termination by employees or contractors with direct patient care responsibilities;

    - Fiscal operation; and

    - Development of policies on beneficiary health and safety, including a comprehensive systemic operational plan to ensure the health and safety of beneficiaries.

- Quality Improvement Plan (QIP) that specifies the following:

    - Identifies areas to improve or maintain the delivery of services and beneficiary care;

    - Develops and implements plans of actions to improve or maintain the quality of care; and

    - Documents and disseminates to PACE staff and contractors the results from the QI activities.

- Establish a beneficiary advisory committee to provide advice to the governing body on matters that concern beneficiaries;

  NOTE: Beneficiaries and beneficiary responsible representatives must constitute the majority of this committee. The beneficiary that serves on the governing body must also participate in this committee and acts as a liaison to the governing body and presents issues from this committee directly to the governing body.

- Establish one or more committees, with community input, to accomplish the following:

  - Evaluate data collected pertaining to quality outcome measures;
  - Address the implementation of and results from the Quality Improvement Plan (QIP); and
  - Provide input related to ethical decision-making, including end-of-life issues and implementation of the Patient Self-Determination Act.

- Be able to provide the complete service package regardless of frequency or duration of services;

- Have a physical site and staff along with equipment to provide primary medical care (including nursing services), treatment, social services, team meetings, , therapeutic recreation, personal care and supportive services, restorative therapies (including physical and occupational therapies), nutritional counseling, recreational therapy, and meals;

- Have a defined service area;

- Have the ability to manage the comprehensive care (including acute and long term) of a complex nursing facility eligible population 365 days a year, 24 hours per day, seven days per week regardless of the setting;

- Develop a provider network in order to provide/contract all required covered services and other services necessary to meet the beneficiary's needs;

- Have policies and procedures that address handling any direct or indirect conflict of interest associated with the governing body, or any contracts that supply administrative or care-related service or materials to the PACE provider;
- Have demonstrated fiscal soundness, as defined in 42 CFR 460.80 and 42 CFR 460.208;
- Have a formal written Beneficiary Bill of Rights, as defined in 42 CFR 460.110 and 42 CFR 460.112;
- Have a process to address grievances and appeals as defined in 42 CFR 460.120 and 42 CFR 460.122;
- Not discriminate against any beneficiary in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, mental, or physical disability or source of payment;
- Follow accepted infection control policies and standard procedures, including at least the standard precautions developed by the Centers for Disease Control and Prevention;
- Establish, implement, and maintain a documented infection control plan that ensures the following:
    - Ensures a safe and sanitary environment;
    - Prevents and controls the transmission of disease and infection;
    - Specifies procedures that identifies, investigates, controls and prevents infections in the PACE centers and the beneficiary's residence;
    - Identifies procedures to record any infection incidents; and
    - Specifies procedures to analyze the infection incidents that identify trends and develops corrective actions related to the reduction of future incidents.
- Establish, implement, and maintain a documented marketing plan with measurable enrollment objectives and a system to track effectiveness as described in 42 CFR 460.82. All marketing material, including any initial, revised or updated marketing material, must be reviewed and approved by CMS and OAAS;

- Have written polices and implement procedures to ensure that the explanation of rights to the beneficiary, his or her responsible representative, and staff are fully explained and understood;

  NOTE: The beneficiary's rights must be in English and in any other principal languages of the community, as determined by the State.

- Have established documented procedures to respond to and rectify a violation of a beneficiary's rights;

- Limit the use of chemical or physical restraints to the least restrictive method as described in 42 CFR 460.114;

- Have a written plan and procedure for handling emergency situations in accordance with 42 CFR 460.84. At least annually the PACE organization must test, evaluate, and document the effectiveness of its emergency and disaster plans to ensure and maintain appropriate responses to situations and needs from both medical and non-medical emergencies. The PACE organization must have a documented plan to obtain emergency medical assistance from sources outside the center when needed; and

- The minimum emergency equipment that must be available for use at each PACE center includes easily portable oxygen, airways, suction, and emergency drugs, along with staff on the premises at all times who know how to use the equipment. The PACE organization must establish, implement and maintain a written plan to ensure that all equipment is maintained in accordance with manufacturer's recommendations.

Emergency Preparedness

In accordance with 42 CFR 460.84 the PACE organization must comply with all applicable Federal, State, and local emergency preparedness requirements. This includes:

- An emergency plan that is reviewed and updated annually;

- Policies and procedures which are reviewed and updated annually and address management of medical and nonmedical emergencies, including, but not limited to:
  - Fire;

- Equipment, power or water failure;
- Care related emergencies; and
- Natural disasters.

- A Communication plan which is reviewed and updated annually;
- A raining and testing plan. The PACE organization must develop and maintain an emergency preparedness training and testing program. The program must be reviewed and updated at least annually;
- Integrated healthcare systems. PACE may choose to participate in another healthcare system's coordinated emergency preparedness program;
- Transportation;
- Ensure transportation services are safe, accessible and equipped to meet the beneficiary's needs;
- Maintain owned, rented, or leased transportation vehicles in accordance with manufacturer's recommendations;

  NOTE: If a contractor/provider provides transportation services, the PACE provider must ensure that the vehicles are maintained in accordance with manufacturer's recommendations.

- Ensure that transportation vehicles are quipped to communicate with the PACE center;
- Train all transportation staff (employees and contractors/providers) to ensure that they can handle the beneficiary's special needs and emergency situations;
- Not use the following marketing practices:
  - Gifts or payments to induce enrollment;
  - Marketing by any individual or entity that is directly or indirectly compensated by the PACE provider based on activities or outcomes unless the individual or entity has been appropriately trained on PACE program requirements, including but not limited to, subparts G and I of this part;

- PACE providers are responsible for the activities of contracted individuals or entities who market on their behalf; and

- PACE providers that choose to use contracted providers, individuals or entities for marketing purposes must develop a method to document training has been provided.

Enrollment and Disenrollment

If there are changes in the PACE Enrollment Agreement information at any time during the beneficiary's enrollment, the PACE organization must:

- Give an updated copy of the information to the beneficiary; and

- Explain the changes to the beneficiary and his or her representative or caregiver in a manner they understand.

A PACE organization must only involuntarily disenroll a PACE beneficiary from the PACE program, in accordance with 42 CFR 460.164, for the following reasons:

- The participant, after a 30 day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medicaid spend down liability or any amount due under the post-eligibility treatment of income process, as permitted under 42 CFR 460.7182 and 42 CFR 460.184;

- The beneficiary engages in disruptive or threatening behavior;

- The beneficiary moves out of the PACE service area or is out of the service area for more than 30 days, unless the PACE organization agrees to a longer absence due to extenuating circumstances;

- The PACE program agreement with CMS and Office of Aging and Adult Services (OAAS) is not renewed or is terminated;

- The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers; and

- The beneficiary is determined no longer to meet Medicaid state nursing facility level of care requirements and is not deemed eligible. The PACE organization must make the determination that the beneficiary no longer meets level of care

and would not reasonably be expected to become eligible for PACE services within 6 months in the absence of continued coverage under the PACE program.

The following behaviors are behaviors considered disruptive or threatening behaviors for purposes of involuntary disenrollment as specified by 42 CFR 460.164(b) (1&2):

- The behavior that jeopardizes his/her health or safety, or the safety of others;
- Consistent refusal to comply with his/her individual plan of care or the terms of the PACE enrollment agreement by a beneficiary with decision making capacity, but not if the behavior is related to a mental or physical condition of the beneficiary unless the participant's behavior jeopardizes his or her health or safety, or the safety of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments;
- A beneficiary's caregiver who engages in disruptive or threatening behavior exhibits behavior that jeopardizes the beneficiary's health or safety, or the safety of the caregiver or others;
- Documentation of disruptive or threatening behavior. If a PACE provider proposes to disenroll a beneficiary who is disruptive or threatening, the PACE provider must document the following;
- The reasons for proposing to disenroll the beneficiary; and
- All efforts to remedy the situation.

Under the authority of Section 903 of the Benefits Improvement and Protection Act (BIPA), a PACE organization must have a CMS approved wavier to expand the request to involuntarily disenroll a beneficiary. This is a request typically made at the time of program development.

- The ability to disenroll a beneficiary for behaviors or actions taken by the beneficiary's family or care giver that renders the beneficiary noncompliant, as specified in 42 CFR 460.164(d); and
- The beneficiary who is permanently placed in a nursing facility fails to pay or to make satisfactory arrangements to pay, the amount of patient liability that would

be required to be paid by a Medicaid eligible resident of a nursing facility if he/she was not a beneficiary in a PACE organization.

The PACE organization must document reasons for the involuntary disenrollment and all efforts to resolve the problem. Involuntary disenrollment shall occur only after all attempts at resolving the issues have been exhausted. The PACE organization must submit all documentation used to support the involuntary disenrollment to the Office of Aging and Adult Services Regional Office (OAAS RO) in accordance with 42 CFR 460.164(e).

The OAAS RO shall submit their preliminary determination to approve/deny the involuntary disenrollment to the OAAS State Office (SO) PACE program designated contact person within 3 business days of receipt of all supportive documentation from the PACE organization. The final justification to proceed with disenrollment will be determined by the OAAS SO within two business days of receipt of the OAAS RO preliminary determination and supporting documentation. OAAS SO shall notify OAAS RO of the final determination if involuntary disenrollment is approved by OAAS SO. The PACE organization shall be notified by the OAAS RO within one business day of receipt of the final determination from OAAS SO.

A participant's involuntary disenrollment occurs after the PACE provider meets the requirements set forth in this section and is effective on the first day of the next month that begins 30 calendar days after the day the PACE provider sends notice of the disenrollment to the beneficiary as specified in 42 CFR.164.

As specified in 42 CFR 460.160(b), an annual interRAI Home Care (interRAI HC) recertification assessment must be completed to reevaluate whether the beneficiary continues to meet level of care required under the state Medicaid plan for coverage of nursing facility services. The PACE applicant must receive an interRAI HC assessment by OAAS trained and certified PACE staff to verify that the applicant continues to meet the required nursing facility level of care criteria for enrollment in PACE.

In accordance with 42 CFR 460.160(b) (2), OAAS may determine that a PACE beneficiary, who no longer meets the State Medicaid nursing facility level of care requirements, may be deemed to continue to be eligible for the PACE program until the next annual reevaluation. The PACE organization may request "deemed continued eligibility" based on the following criteria:

- The beneficiary no longer meets the nursing facility level of care criteria but would reasonably be expected to become eligible within six months in the absence of continued coverage under the program; and

- The beneficiary's medical record and plan of care support deemed continued eligibility.

The PACE organization must submit the request for Deemed Continued Eligibility Form (OAAS-PF-10-002) to the OAAS RO within five business days of notification of a PACE beneficiary not having met nursing facility level of care.

The PACE IDT must submit a brief justification summary and supporting documentation from the beneficiary's medical record/Plan of Care that supports the request for Deemed Continued Eligibility Form (OAAS-PF-10-002). Supporting documentation includes any information that, in the absence of PACE services, the beneficiary would reasonably be expected to experience a decline in functional abilities or health to a degree that he/she would meet nursing facility level of care criteria within six months.

Examples of supporting documentation include, but are not limited to:

- Diagnosis of a chronic, and/or disabling condition;
- Physician and/or nursing progress notes documenting the treatment of the chronic, and/or disabling condition(s);
- Physician's Orders and a list of services currently provided to the beneficiary (e.g. physical therapy, occupational therapy, dietary management, blood pressure checks, etc.); and
- Frequency of medical appointments and/or frequency of medical treatments/interventions that point to unstable medical condition that must be treated, and or monitored to avoid complications.

OAAS RO shall review all documentation and respond within 10 business days upon the receipt of the request and all supporting documentation. OAAS RO may request an onsite visit to meet with the beneficiary, conduct its own level of care assessment and/or request additional information. The PACE organization must submit the requested information no later than 5 business days from the date of receipt of OAAS' request for the additional information. If OAAS does not receive the requested information within the five business days, OAAS shall proceed with the denial process.

The PACE organization will be notified in writing via the Deemed Continued Eligibility Form (OAAS-PF-10-002) if the OAAS RO deems continued eligibility and enrollment will continue until the next annual reassessment.

OAAS RO shall make a notation in the interRAI HC Notebook that deemed continued eligibility

criteria met on -------- (date goes in the blank space) for continuation of PACE program until next annual interRAI HC reassessment.

The PACE organization shall continue to conduct annual interRAI HC reassessments for level of care and may request Deemed Continued Eligibility each year as appropriate.

LDH may permanently waive the annual recertification of level of care requirements for a beneficiary if it determines that there is no reasonable expectation of improvement or significant change in the beneficiary's condition because of the severity of a chronic condition. Beneficiary's annual re-assessments shall continue for OAAS research purposes.

Staffing Requirements

The PACE provider must:

- Not employ individuals, contract with organizations/providers or individuals who have been;
- Excluded from participation in the Medicare and/or Medicaid programs;
- Convicted of Medicare, Medicaid, or other health insurance or health care programs, or any social service program (under title XX of the act) related crimes;
- Convicted of physical, sexual, drug or alcohol abuse in a capacity where an individual's contact with beneficiaries would pose a potential risk;
- Found guilty of abusing, neglecting or mistreating individuals by a court of law or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;
- Convicted of specific crimes for any offense described in section 1128(a) of the Social Security Act;
- Ensure that all members of the interdisciplinary team have appropriate licenses or certifications under State law, and act within the scope of practice as defined by State laws; and

- Develop a training program for each personal care attendant to establish the beneficiary's competency in furnishing personal care services and specialized skills associated with the beneficiary's specific care needs.

  NOTE: Personal care attendants must exhibit competency before performing personal care services.

The PACE provider must ensure that each member of its staff (employees or contractors/providers) that has direct contact with beneficiaries, must meet the following criteria:

- Be legally authorized to practice in Louisiana (e.g. currently licensed, registered or certified, if applicable);
- Only act within the scope of his/her authority to practice;
- Have 1 year of experience working with frail or elderly population or if the individual has less than 1 year of experience but meets all other requirements as stated above, he/she must receive appropriate training from the PACE provider on working with a frail or elderly population upon hiring;
- Meet a standardized set of competencies for the specific position description established by the PACE provider before working independently;
- Be medically cleared for communicable diseases and have all immunizations up-to-date before engaging in direct beneficiary contact;
- Demonstrate the skills necessary for performance of their position;
- Comply with any State and/or Federal requirements for direct beneficiary care staff in their respective settings;
- Oriented to the PACE; and
- Agree to abide by the philosophy, practices and protocols of the PACE provider.