PROVIDER REQUIREMENTS

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

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

2. 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

3. Comply with all of the terms and conditions for Medicaid enrollment.

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

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

Providers must document that criminal record history checks have been obtained and that employees and the employees of subcontractors do not have a criminal record as defined in R.S. 40:1203.1 et seq. Providers are not to employ individuals who have been convicted of abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. Providers must take all reasonable steps to determine whether applicants for employment have histories indicating involvement in abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual.

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

1. Recoupment;

2. Sanctions;

3. Loss of enrollment; or

4. Loss of licensure.

Providers must also check the Certified Nursing Assistant (CNA) and Direct Service Worker (DSW) Registries for placement of findings of abuse, neglect, or misappropriation and shall be in accordance with licensing regulations.

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 waiver provider. A Provider Enrollment Packet must be completed by the provider for each provider type and for each LDH administrative region in which the agency or provider will deliver 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 for that provider type.

Long Term – Personal Care Services (LT-PCS) are to be provided strictly in accordance with the provisions of the approved plan of care (POC). All providers and/or contractors are obligated to immediately report any changes to LDH that could affect the beneficiary's eligibility.

Providers are responsible for documenting the occurrence of incidents or accidents according to their company's policy.

Providers must:

1. Participate in all training for prior authorization (PA) and data collection. Initial training is provided at no cost to the provider. Any repeat training must be paid for by the requesting provider; and

2. Have available computer equipment software, and internet connectivity necessary to participate in prior authorization, data collection, and Electronic Visit Verification (EVV).

Licensure and Specific Provider Requirements

Providers must meet licensure and other additional requirements as outlined in the table below:

Personal Care Services
Provided by a PCS provider that: 1. Is licensed by the LDH Health Standards Section (HSS) as a PCS provider; 2. Has enrolled in Medicaid as a PCS provider; and 3. Is listed on the FOC form.

Provider Responsibilities

LT-PCS providers must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective licensing authorities and in accordance with all applicable LDH and the Office of Aging and Adult Services (OAAS) rules and policies.

Providers shall not refuse to serve any beneficiary who chooses their agency, unless there is documentation to support an inability to meet the beneficiary's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services. OAAS, or its designee, must be notified immediately of the circumstances surrounding the refusal. The refusal request must be made in writing by the provider to OAAS, or its designee, and to the beneficiary detailing why the provider is unable to serve the beneficiary. This requirement can only be waived by OAAS or its designee.

Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

If the provider proposes **involuntary transfer, discharge of a beneficiary, or if a provider closes** in accordance with licensing standards, the following steps must be taken:

1. The provider shall give written notice to the beneficiary, a family member and/or the responsible representative, if known, at least 30 calendar days prior to the transfer or the discharge.

2. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the beneficiary understands.

3. A copy of the written discharge/transfer notice shall be put in the beneficiary's record.

4. When the safety or health of beneficiaries or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge.

5. The written notice shall include the following:

    a. A reason for the transfer or discharge;

    b. The effective date of the transfer or discharge;

    c. An explanation of a beneficiary's right to personal and/or third party representation at all stages of the transfer or discharge process;

d. Contact information for the Advocacy Center;

e. Names of provider personnel available to assist the beneficiary and family in decision making and transfer arrangements;

f. The date, time and place for the discharge planning conference;

g. A statement regarding the beneficiary's appeal rights;

h. The name of the director, current address and telephone number of the Division of Administrative Law (DAL); and

i. A statement regarding the beneficiary's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include:

1. Holding a transfer or discharge planning conference with the beneficiary, family, support coordinator, legal representative and advocate, if such is known;

2. Developing discharge options that will provide reasonable assurance that the beneficiary will be transferred or discharge to a setting that can be expected to meet their needs;

3. Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the beneficiary; and

4. Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

NOTE: The requirements above do not apply when the beneficiary is being discharged from the LT-PCS program by LDH or OAAS.

Failure of the provider to meet the minimum standards shall result in a range of required corrective actions including, but not limited to, the following:

1. Removal from the FOC listing;

2. A citation of deficient practice;

3. A request for corrective action plan; and/or

4. Administrative sanctions.

Continued failure to meet the minimum standards may result in disenrollment as an LT-PCS provider.

LT-PCS providers must complete and submit the LDH approved cost report(s) to the LDH designated contractor no later than five months after the state fiscal year ends (June 30). (See Appendix B to obtain web address for additional information).

Back-up Staffing Plan

Providers must have a written back-up plan for each LT-PCS beneficiary in the event the assigned worker is unable to provide support due to unplanned circumstances or emergencies which may arise. This plan must be developed and maintained in accordance with licensing standards and include:

1. Person or persons responsible for back up coverage (including names, relationships, and contact phone numbers);

2. A toll-free telephone number with 24-hour availability manned by an answering service that allows the beneficiary to contact the provider if the worker fails to show up for work; and

3. Signatures and dates.

If providers use a pool of on-call or substitute workers to ensure that services to the beneficiary will not be interrupted, those workers must meet the same qualifications as the regular LT-PCS workers.

In all instances when a worker is unable to provide support, they must contact the provider and family/beneficiary immediately.

Back-up staffing plans **must** be provided to beneficiaries and/or their personal representative before services begin.

Emergency Plan

Providers must also ensure that each beneficiary has a documented individualized emergency plan in preparation for, and response to, emergencies and disasters that may arise. This plan must identify specific resources available through family, friends, the neighborhood and the community.

Worker Qualifications

All staff providing direct care to the beneficiary must meet the qualifications set forth in the licensing regulations found in the Louisiana Administrative Code (LAC Title 48, Chapter 50 and Chapter 92).

Family members who provide LT-PCS must meet the same standards for employment as caregivers who are unrelated to the beneficiary. (Refer to the link in Appendix A for further clarification).

Changes

Changes in the following areas are to be reported in writing to HSS, OAAS and the fiscal intermediary's Provider Enrollment Section, within the time specified in the HSS licensing rule:

1. Provider's entity name ("doing business as" name);
2. Key administrative personnel;
3. Ownership;
4. Physical location;
5. Mailing address;
6. Telephone number; and
7. Account information affecting electronic funds transfer (EFT).

When a provider closes or decides to no longer participate in the Medicaid program, the provider must give at least a 30 calendar day written advance notice to all beneficiaries served and their responsible representatives, and LDH (OAAS and HSS) prior to discontinuing service.