



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid)

Office of Aging and Adult Services Case Management (Support Coordination)

(Enrollment packet is subject to change without notice)

**PROCESS TO BECOME A MEDICAID (TITLE XIX) ENROLLED
SUPPORT COORDINATION AGENCY ADMINISTERED BY OFFICE OF AGING AND ADULT SERVICES**

After the Support Coordination agency receives certification to operate, the Health Standards Section (HSS) will submit the following information to the Office of Aging and Adult Services (OAAS):

Name and address of the agency
Telephone, Fax Number and Email address of the agency
Name of the
Director
Effective Date of Certification

Your agency must contact OAAS, prior to enrolling with Medicaid. Medicaid Provider Enrollment will not process your enrollment packet until your agency has completed the following OAAS requirements in the order listed below:

- Provide to OAAS a copy of Health Standards Certification.
- Provide to OAAS the "OAAS Support Coordination Performance Agreement Signature Form" (*i.e.*, the original signed form)
- Purchase a Citrix Account at a cost of \$385.15 (price subject to change without notice). This account allows access to client assessment information. Initially, your agency will have access to a test site only. Full access will be made available after your agency has been approved as an enrolled provider. Call (225)342-6491 to purchase.
- One support coordinator supervisor and one support coordinator must complete and pass the Assessment and Care Planning Certification Training and attend orientation by the OAAS regional office. Information about the Assessment and Care Planning Training can be found at the OAAS website: <http://new.dhh.louisiana.gov/index.cfm/page/463>
- Submit support coordination agency brochure to OAAS for approval.
- Provide to OAAS the completed "OAAS Support Coordination Agency Key Personnel/Contact Information" form

Once all requirements are met, OAAS will issue an approval letter and the agency may continue with the enrollment process. This approval letter must be included in the Provider Enrollment packet.

If all requirements are not met, agency will be issued a denial letter and enrollment cannot continue until all requirements as set forth above are met

Upon approval from OAAS, complete the Basic Enrollment Packet for the Louisiana Medical Assistance Program (Louisiana Medicaid Program) and the Provider Type Specific Packet/Checklist for Office of Aging and Adult Services Case Management as instructed.

Any questions regarding the Medicaid Enrollment packet should be submitted to Molina Provider Enrollment at 225/216-6370. Once your application has been processed by the Provider Enrollment section, your provider number will be mailed to you. Provider Enrollment will notify OAAS and your agency will be added to the Freedom of Choice (FOC).

Once you've been added to the FOC form and you receive your first linkage (referral) you need to contact Statistical Resources, Inc. (SRI) at 225/767-0501 to complete Case Management Information System (CMIS) training.

Any change in information provided during this enrollment process must be reported to OAAS.

(Reissued August 16, 2011 OAAS-SC-11-010)

GENERAL INFORMATION FOR PROVIDER ENROLLMENT

Provider Enrollment works on a three-week turnaround time frame. If enrollment requirements are not met, the entire application will be returned for correction and would need to be re-submitted once the corrections are made. Any re-submission of the enrollment packet is subject to additional three-week turnaround period.

The effective date for this enrollment will be the day the application is actually worked by Provider Enrollment.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be made to the provider regarding automatic closure.

If at any time during enrollment as a Medicaid provider, the provider has a change of physical address, the provider must first obtain an updated license indicating the new address, and then submit notification of the change of address along with a copy of the updated license/certification to Molina Medicaid Solutions Provider Enrollment (use the File Update form to submit address change – mailing address located at the bottom of this form).. This change must also be reported to the Office of Aging and Adult Services. Failure to report a change of address will result in your agency being incorrectly listed on the freedom of choice list.

Providers enrolled as type 08 (OAAS Case Management [Support Coordination]) are allowed to provide waiver case management services in accordance with applicable rules, regulations and policies to recipients of:

- OAAS Community Choices Waiver
- OAAS Adult Day Health Care Waiver

NOTICE TO WAIVER SERVICE PROVIDERS

Please note that Louisiana Medicaid will only reimburse you for waiver services rendered to Medicaid recipients who are enrolled in a waiver program (New Opportunities Waiver (NOW), Children's Choice Waiver, Supports Waiver, Residential Options Waiver (ROW), Adult Day Health Care (ADHC) Waiver and Community Choices Waiver). Medicaid will not reimburse you for waiver services provided to recipients who are not enrolled in one of the waiver programs.

ATTENTION

Waiver service providers are required to comply with all requirements contained in:

The provider manuals located at

<http://www.lamedicaid.com>

And

The information located on the DHH/OAAS website at

<http://new.dhh.louisiana.gov/index.cfm/subhome/12/n/7>

Elderly Case Management

CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Office of Aging and Adult Services (OAAS) Case Management provider:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/> *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	<p>4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. (Only the Disclosure of Ownership portion of this enrollment packet can be done online by choosing Option 1.)</p> <p>Option 1: Provider Ownership Enrollment Web Application. Go to www.lamedicaid.com and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist.</p> <p style="text-align: center;">-or-</p> <p>Option 2: If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.</p>
<input type="checkbox"/> *	5. (If submitting claims electronically) Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form and Power of Attorney Form (if applicable).
<input type="checkbox"/>	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited (deposit slips are not accepted) .
<input type="checkbox"/>	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (W-9 forms are not accepted) .
<input type="checkbox"/>	8. Copy of the Case Management (Support Coordination) license/certification from the Department of Health and Hospitals, Health Standards Department.
<input type="checkbox"/> **	9. Completed Louisiana Medicaid Program Board Resolution Form. ** (Must be notarized.)
<input type="checkbox"/>	10. Copy of approval letter from OAAS that indicates all OAAS requirements have been met.
<input type="checkbox"/>	11. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 81 (Case Management).

* These forms are available in the **Basic Enrollment Packet for Entities/Businesses**.

** This form included here.

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT.

ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS)

Please submit all required documentation to:
Molina Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Office of Aging and Adult Services

OAAS Requirements for Support Coordination Brochures

Brochures must include the following information; format may be determined by the agency:

1. Each recipient of Medicaid waiver and targeted support coordination has the freedom to choose their provider. The individual's choice of support coordination or direct service provider does not affect their eligibility for waiver and state-plan programs or support coordination services.
2. Medicaid recipients receiving support coordination services through the Office of Aging and Adult Services (OAAS) may contact the OAAS Help Line at 1-866-758-5035 for information, assistance or questions about OAAS programs. The brochure may also include the appropriate OAAS regional office telephone numbers.
3. Complaints about support coordinators, support coordination agencies or direct service providers may be reported to the Health Standards Section at 1-800-660-0488.
4. The brochures must include a description of the agency, the services provided, current address and the agency's local and nationwide toll-free number. The brochure may also include the agency's experience delivering support coordination services.

Support Coordination shall be responsible for:

1. Obtaining written approval of the brochure from the OAAS support coordination program manager prior to distributing to recipients of the Elderly and Disabled Adult waiver, Adult Day Health Care waiver or other OAAS programs. All marketing material must be approved by DHH prior to distribution by the agency.
2. Providing DHH or its designated contractor with adequate supplies of the approved brochure.
3. Completing revisions of the brochures, as requested, to reflect all program changes.

Reissued July 16, 2007

Replaces OAAS Addendum issued May 4, 2007
to Case Management Service Provider
Manual issued July 1, 2002

OAAS –SC-07-006

Louisiana Medicaid Program Board Resolution Form

STATE OF LOUISIANA, PARISH OF _____

On the _____ day of _____, 20____

At a meeting of the Board of Directors of _____

Held in the City of _____ Parish of _____

A quorum of the Directors present, the following business was conducted:

It was duly moved and seconded that the following resolution be adopted:

BE IT RESOLVED that the Board of Directors of the above corporation hereby authorized

(Name and Title)

and his/her successors in the office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Louisiana Department of Health and Hospitals, and to execute said documents on behalf of the corporation, and further do we hereby give him/her the power and authority to do all things necessary to implement, maintain, amend or renew said documents.

The above resolution was passed by a majority of those present and voting in accordance with the by-laws and articles of incorporation.

I certify that the above and foregoing constitutes a true and correct copy of a part of the minutes of a meeting of the Board of Directors of _____

held on the _____ day of _____, 20____

Secretary

Subscribed and sworn before me, _____

a Notary Public for the Parish of _____

on the _____ day of _____.

**OFFICE OF AGING AND ADULT SERVICES (OAAS)
SUPPORT COORDINATION AGENCY
PERFORMANCE AGREEMENT**

(Name of Support Coordination Agency)

1. PURPOSE

The Office of Aging and Adult Services (OAAS) Support Coordination Agency Performance Agreement, hereafter referred to as the **AGREEMENT**, is an addendum to the Louisiana Medicaid PE-50 Provider Enrollment Form. OAAS reserves the right to revise and reissue the **AGREEMENT** as deemed necessary. The purpose of the **AGREEMENT** is to ensure that:

the Support Coordination agency, hereafter referred to as the **AGENCY**, shall provide effective outcome-based support coordination services in accordance with applicable federal and state regulations, rules, policies, procedures and standards; and, the **AGENCY** shall deliver such services through the use of trained, knowledgeable staff who are competent in developing a person-centered plan of care; and, the **AGENCY** shall assure that said staff are able to effectively assess a participant's condition and informal support systems, and to develop a person-centered plan of care using available paid and unpaid supports; and, unless approved by OAAS, the **AGENCY** will not have the ability to reject or deny support coordination services to an approved participant; and in order to receive reimbursement for the provision of such services, a fully-executed version of the **AGREEMENT** between the **AGENCY** and the Office of Aging and Adult Services, hereafter referred to as **OAAS**, shall be in place; and, participants receiving services provided under this **AGREEMENT** will have freedom of choice of licensed and/or certified, Medicaid enrolled **AGENCIES** that have a current **AGREEMENT** with **OAAS**.

2. ELIGIBLE ENTITIES

In order to participate as a support coordination **AGENCY** in the Medicaid program, the **AGENCY** must comply with the Department of Health and Hospitals' licensure and/or certification requirements, provider enrollment requirements, the OAAS Support Coordination Provider Manual, the OAAS Support Coordination Procedural Manual, and other requirements as enumerated in Section 3 **AUTHORITY**, below.

3. AUTHORITY

The following documents are considered as the Authority under which the AGENCY must conduct its activities under the AGREEMENT. The requirements outlined in the Rules, Standards, Statutes, Regulations, and other documents are promulgated in accordance with State and Federal law, the Administrative Procedures Act, and other relevant methods as required by law.

While OAAS will make every effort to inform the AGENCY of any changes/modifications to the requirements of the Rules, Standards, Statutes, Regulations, and other documents governing the AGREEMENT, it is the responsibility of the AGENCY to assure it is operating in accordance with those requirements. A failure to comply with any requirement because of a lack of knowledge of the requirement will not be accepted as a means of defense to any proposed sanctions or other action taken by DHH/OAAS due to the violation of the requirements. In order to participate as a support coordination AGENCY in the Medicaid program, the AGENCY must comply with:

- Licensure and/or certification requirements;
- Provider enrollment requirements;
- OAAS Support Coordination Provider Manual;
- OAAS Support Coordination Procedural Manual;
- Performance Agreement for OAAS Support Coordination Agencies.

These materials and other related documents may be viewed online at the OAAS website: www.oaas.dhh.louisiana.gov

4. PARTICIPATION

In order to be recognized as an AGENCY as described herein, and to receive appropriate reimbursements for the provision of services, in addition to the requirement noted in Section 2 and Section 3 above, the AGENCY must comply with specific requirements established by OAAS as follows:

- Cooperate in DHH/OAAS Support Coordination Monitoring ;
- Cooperate in all other Quality Monitoring activities;
- Support Coordinators and Support Coordinator Supervisors shall work exclusively with OAAS participants;
- Complete all mandated training; meet certification requirements;
- Implement Support Coordination services/safeguards in accordance with the Centers for Medicare and Medicaid Services (CMS) HCBS waiver assurances and corresponding OAAS performance measures (“CMS Training for Case Managers” on the HCBS waiver assurances may be accessed at: www.hcbsassurances.org/index.html); and

5. PAYMENTS TO AGENCY

Payments/reimbursement for services provided by the AGENCY under the AGREEMENT will be made through claims submitted to the Medicaid Fiscal Intermediary in accordance with the methodology described in the documents referred to in Section 3 AUTHORITY.

6. LIABILITY FOR UNJUSTIFIED AND/OR UNAUTHORIZED AND/OR INCORRECTLY AUTHORIZED PAYMENTS

AGENCY may be held financially liable for any error/omission on its part which results in the delivery and reimbursement of unjustified or unauthorized services as determined by OAAS.

7. ADMINISTRATIVE PERFORMANCE REQUIREMENTS

The AGENCY is accountable for meeting specific fundamental administrative performance expectations as delineated in this Section.

Failure to meet any of the following provisions on the part of the AGENCY may result in sanctions as outlined in Section 10 of this Agreement:

- Complete and submit **TIMELY** administrative reports to include: Aging Reports, Critical Incident Reports, Evacuation Tracking Reports, Data Contractor Problem Sheets, and other Reports as determined by DHH/OAAS;

- Complete and submit **TIMELY** Level of Care assessments/determinations;

- Complete and submit **TIMELY** plans of care;

- Complete and submit **TIMELY** plan of care revisions;

- Complete and submit **TIMELY** Forms 148 and 142;

- Provide **TIMELY** plan of care and any subsequent revisions to participant and provider(s)

- Abide by the **SUPPORT COORDINATION MONITORING** requirements;

- Maintain **QUALIFIED, CERTIFIED, and COMPETENT** staff in accordance with State requirements; and

- Assure that participant addresses, contact information and other relevant personal data are maintained and updated in a timely manner.

- Support Coordinator or AGENCY representative must participate in appeal hearings to represent/testify to the accuracy of the assessment/plan of care completed by the support coordinator.

8. HEALTH AND WELFARE REQUIREMENTS

Through direct contact, familiarity with the home environment, and, familiarity with personal outcomes of the participant the Support Coordinator is instrumental in promoting the participant's health and welfare. It is incumbent upon the Support Coordinator to identify and report critical events, implement safeguards, make referrals, mitigate risks, follow-up/evaluate interventions, and strive to prevent future occurrences that may have a negative impact on the participant's health and welfare.

Any of the following actions/inactions on the part of the AGENCY may result in sanctions as outlined in Section 10 of this Agreement:

- Comply with monthly contact requirements;
- Comply with quarterly face-to-face contact requirements;
- Identify and address all participant needs and risks on an ongoing basis;
- Address personal goals in the plan of care;
- Ensure participant receives all types of services specified in plan of care;
- Support participant in accessing all services in plan of care, including health care services;
- Verify direct service provider delivery of services;
- Follow-up with appropriate oversight entity when direct service provider is non-compliant with service delivery;
- Provide/review information with participants regarding Rights and Responsibilities;
- Review information with participants regarding how to report abuse, neglect, and critical incidents;
- Offer participants freedom of choice;
- Identify risks associated with abuse, neglect, exploitation;
- Report suspected cases of abuse, neglect, or exploitation;
- Develop an adequate AGENCY evacuation/continuity of business plan;
- Follow grievance and complaint procedures;
- Reassess participant when significant changes occur;
- Revise service plan to address participant's changing needs;
- Ensure participant emergency preparedness and staffing back-up plans are current and viable;
- Report or follow-up on critical incidents;
- Implement AGENCY emergency preparedness and response plan effectively in the event of disaster;

Cooperate with DHH and other emergency preparedness agencies in the event of impending or actual disaster. Cooperation includes, but is not necessarily limited to, contacting participants and reporting on participant status in accordance with OAAS policies and procedures.

In addition, sanctions may be imposed in the following circumstances:

Retaliation aimed at participants/family members for complaints against the AGENCY;

Negligence directly or indirectly resulting in participant serious harm or death;

Engaging in a pattern of recurring or continuing non-compliance; and

Failure to implement agency emergency preparedness and response plan in the event of disaster

9. PERFORMANCE INCENTIVES

For those AGENCIES meeting OAAS performance criteria, the following incentives may be conferred:

Priority auto-assignment of participants who do not choose an AGENCY.

Recognition and designation as a “Model Support Coordination Agency” on the Freedom of Choice list.

Omit the AGENCY Review component of the annual Support Coordination Monitoring Review.

10. SANCTIONS FOR VIOLATIONS/NON-PERFORMANCE

In order to remain in good standing with OAAS and eligible to continue the provision of services under the AGREEMENT, the AGENCY must comply with the Administrative Performance Requirements and the Health and Welfare Requirements enumerated in Sections 4, 6, 7 and 8 above. Should the AGENCY be determined to be in violation or non-compliance with those requirements, OAAS/Medicaid reserves the right to impose Sanctions on the AGENCY, with or without prior notice. Such Sanctions may include, but are not limited to, the following which are BINDING and NOT SUBJECT TO APPEAL:

Written warning

Written mandate for documentation of acceptable remediation plan/demonstration of compliance with rules/regulations/agreement

Impose training and accountability measures

Impose further performance requirements

Moratorium on admissions and/or expansion of services (i.e. Removal from FOC list)

Remove designation as “Model Support Coordination Agency” on the Freedom of Choice list.

In addition to the measures described above, sanctions may also include, but are not limited to, the following:

- Removal of existing participants
- Suspend payments in whole or part for a specific time period
- Recoupment
- Denial of reimbursement for undocumented services
- Impose daily, weekly, or monthly fines
- Impose fines per day per incident for health and welfare issues
- Licensure and/or certification suspension/limitation/revocation
- Termination of the Performance Agreement

In addition, if action or inaction on the part of the AGENCY results in federal disallowance, the AGENCY shall be held liable to recoupment of those amounts.

In addition, any AGENCY who fails to comply with all Medicaid/OAAS Rules, Standards, Statutes, Regulations, and/or Manuals may be referred to the Program Integrity Section for further sanctions.

11. SANCTION DETERMINATION

The following factors will be considered in determining sanctions to be imposed:

- Seriousness of the violation;
- Extent of the violation;
- History of prior violations;
- Impact on participant quality of life;
- Impact on participant health and welfare;
- Prior imposition of sanctions;
- Pattern of non-compliance;
- AGENCY incentive to comply with program rules;
- Recommendations by peer review groups or licensing boards; and
- Any other factors deemed critical by DHH/OAAS.

12. DUE DATE OF MONETARY SANCTIONS

Impositions of any damage shall not be suspensive. Any and all monetary sanctions/recoupment shall become due and payable upon written notification from DHH/OAAS. Failure to remit payment within 10 working days may result in withholding of the AGENCY's payments until all outstanding monetary sanctions/recoupment are paid, unless an administrative appeal is pending. If DHH/OAAS should prevail at the administrative appeal, payment is due within 10 working days from the date of the decision. Failure to remit payment within 10 working days from the date of decision may result in withholding of the AGENCY's payments until all outstanding fines are paid, and may result in additional non-monetary sanctions.

13. APPEALS

Specified Sanctions administered by OAAS in accordance with the AGREEMENT may be appealed by the AGENCY, and the AGENCY has a right to an administrative hearing. A request for an administrative hearing must be received within thirty (30) days from the date of written notice of the Sanction. The request must be made in writing and mailed or faxed directly to:

**Division of Administrative Law-HH Section
P.O. Box 4189
Baton Rouge, LA 70821-4189
Telephone: 225-342-0443
Fax: 225-219-9823**

**OFFICE OF AGING AND ADULT SERVICES (OAAS)
SUPPORT COORDINATION AGENCY
PERFORMANCE AGREEMENT**

Name of AGENCY _____

Address: _____

Telephone #: _____

Fax #: _____

Email: _____

Contact Person: _____

AGENCY Signature(s) and Date

DHH/OAAS Signature(s) and Date
