



# **PROVIDER TYPE SPECIFIC PACKET/CHECKLIST**

**(Louisiana Medicaid Program)**

# **NURSING FACILITY**

(Enrollment packet is subject to change without notice)

# GENERAL INFORMATION FOR THE NURSING FACILITY PROVIDER TYPE

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.

## Nursing Facility Provider Type CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as a Nursing Facility 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. <b>(Only the Disclosure of Ownership portion of this enrollment packet can be done online by choosing Option 1.)</b></p> <p><b>Option 1</b> (preferred): Provider Ownership Enrollment Web Application. Go to <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> 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;"><b>-or-</b></p> <p><b>Option 2</b> (not recommended): 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. <b>(If submitting claims electronically)</b> Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form <b>and</b> 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 <b>(deposit slips are not accepted)</b> .
<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 <b>(W-9 forms are not accepted)</b> .
<input type="checkbox"/>	8. Copy of Nursing Home License from Health Standards.
<input type="checkbox"/>	9. Copy of Medicare Certification Letter confirming enrollment with Medicare as a Nursing Facility.
<input type="checkbox"/> **	10. Completed Provider Agreement (four pages).
<input type="checkbox"/> **	11. Completed Addendum to Provider Agreement, if applicable (one page).
<input type="checkbox"/>	12. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 86 (Hospitals and Nursing Homes).

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

\*\* Forms 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 Medicaid Solutions Provider Enrollment Unit**  
**PO Box 80159**  
**Baton Rouge, LA 70898-0159**

# PROVIDER AGREEMENT

FOR SKILLED NURSING FACILITY AND/OR INTERMEDIATE CARE FACILITY I OR IXX PARTICIPATION IN THE LOUISIANA STATE MEDICAL ASSISTANCE PROGRAM (TITLE XIX)

This agreement entered into by and between: STATE OF LOUISIANA, by and through the Department of Health and Hospitals, hereinafter referred to as Agency, AND \_\_\_\_\_, located at \_\_\_\_\_ hereinafter referred to as the Provider, represented herein by \_\_\_\_\_, \_\_\_\_\_ (title).

## WITNESSETH

WHEREAS, persons eligible for care under the Louisiana Medical Assistance Program operating under Title XIX of the Social Security Act are in need of medical care and services in the form of institutional services,

WHEREAS, Section 1902 (a) (27) of Title XIX of the Social Security Act requires states to enter into a written agreement with every person or institution providing services under the State Medical Assistance Program,

WHEREAS, the Provider has filed an application with the Agency to provide certain medical care and services to any and all persons eligible under the Louisiana Medical Assistance Program,

WHEREAS, the Agency has licensed the Provider under the laws of the State of Louisiana,

WHEREAS, the Provider has been certified by the Licensing authority of the State of Louisiana as meeting all applicable health and safety standards for participation in the Louisiana Medical Assistance Program for provision of services for which it has been duly certified as follows:

The facility has been certified for \_\_\_\_\_ type of service(s)

As being in full compliance with the standards of participation

As being in full compliance with the standards of participation with waiver or

As being in compliance for participation with correctable deficiencies

NOW THEREFORE, the aforesaid application is approved by the Agency subject to the following stipulations, terms and conditions:

A. The Provider agrees

1. To be in compliance with and maintain the federal and state health and safety standards relative to the type of services for which it is certified to provide.
2. To comply with all rules and regulations promulgated by Agency with regard to STANDARDS FOR PAYMENT TO SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES I AND II PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM (TITLE XIX), which are applicable to the type(s) for service for which the facility is certified and with Title XIX Cost Related Reimbursement Regulations as adopted by the Agency's Medical Assistance Program.

3. To provide the level type of care for which recipient is certified to need and in accordance with the level of care and type of services facility is certified to provide.
4. To keep the information in the Provider Enrollment OS Form(s) PE-50 and ownership data current with the understanding that the Provider Enrollment Form(s) and ownership data become a part of this contract and that each succeeding change in the Provider Enrollment Form constitutes an amendment to the contract and that failure to keep the information current constitutes a breach of the contract.
5. To notify the Agency prior to any change of ownership or of any transaction affecting the operation of the Provider, as defined by the Standards for Payment.
6. To accept, as payment in full, the amounts paid in accordance with established fees for services billed.
7. That Agency and Department of Health, Education, and Welfare representatives may have access to data indicating charges by Provider.
8. That no person shall, on the ground of race, color, or national origin, be subjected to discrimination, be excluded from participation in, or be denied the benefits of the services provided by the terms of this agreement, as provided in Standards for Payment.
9. That no employee or applicant for employment shall be subjected to discrimination because of race, color, religion, sex, or national origin as provided in the Standards for Payment.
10. To keep such records for the period of time specified in the Standards for Payment as are necessary fully to disclose to extent to the services provided to individuals receiving assistance under the Louisiana Medical Assistance Program.
11. To furnish the State Agency with such information regarding any payments for required services claimed by such person or institution under the Louisiana Medical Assistance Program as the State Agency may from time to time reasonably request.

B. The Agency Agrees:

1. To pay such facility services as indicated above in the form of vendor payments for all persons receiving required services who have been determined to be eligible for such assistance under the Louisiana Medical Assistance Program, in accordance with the existing or modified rate established by the Agency based upon the Department of Health, Education, and Welfare approved Louisiana Title XIX Cost Related Reimbursement Program for services furnished pursuant to the requirements of the Standards for Payment.
2. To make such payments in accordance with the applicable laws and by the tenth of the month following month for which the services were rendered, and a proper claim is submitted and approved.

A penalty of not more than 1.5% per month may be charged to a patient for any account thirty days or more past due, provided that such penalty may be charged only upon that portion of the total amount for which the patient is responsible, and shall not be charged on that portion of the account payable by the Provider. This is not a charge for service but a penalty for late payment of applicable income.

3. That in the event the Agency determines certain costs which have been reimbursed to Provider pursuant to this or previous agreements are not allowable, Agency shall have the right to set off and withhold said amount from amounts due the Provider under this agreement for costs that are allowed.
4. To give to Provider at least thirty (30) days notice of any impending change in its status as a participating facility; provided, however, that Agency shall have the right to terminate this agreement immediately, if documented evidence indicates the continued operation of this agreement would jeopardize the health and welfare of medical assistance recipients under the Provider's care.
5. However, should Agency terminate this agreement immediately for this reason, Agency may continue to make payments to Provider for a period not to exceed thirty (30) days from date of termination, provided that Provider assists in an orderly plan for transfer of the affected medical assistance recipients.

C. The parties hereby mutually agree:

1. That this agreement shall be performed in a manner consistent with the provisions of Title XIX of the Social Security Act and of the Standards for Payment. Any future modifications or amendments to said Act or said Standards shall likewise be binding on the parties hereto.
2. That the Agency may withhold payments in whole or in part if necessary because of any non-compliance with the Standards for Payment required by the Agency.
  - a) Upon failure of Provider to submit the completed required staffing report to Agency on established date and after Agency has notified Provider of such, vendor payment may be withheld until completed report has been received.
  - b) When Agency determined that incorrect or inappropriate charge(s) have been levied by the Provider against recipient or his responsible person or there has been a misapplication of patient funds, a sum not to exceed the inappropriate charge, or misapplied patient funds may be withheld until restitution has been made and documentation submitted to OS.
  - c) When required staffing reports indicate unapproved nurse staffing shortage, vendor payment may be withheld until such time as staffing is brought into compliance.
  - d) For failure to submit a cost report within ninety (90) days of the Provider fiscal year closing date, a penalty of 5% of the total monthly payment for each month of non-compliance may be levied. The Agency may grant an extension of the ninety- (90) day time limit upon request of the Provider after having shown just cause. Penalty

- may be a progressive penalty of 5% for each succeeding month on non-compliance.
- e) Upon failure of Provider to secure physician's re-certification of the need for care and service of a substantial number of assistance recipients as often as the Standards for Payment mandate, the vendor payment may be withheld in whole or in part until such time as compliance is achieved.
- f) Upon repeated failure of Provider to insure that an adequate plan of care, (as defined in the Standards for Payment) for a substantial number of medical assistance recipients is reviewed at least at minimum intervals, as established in the Standards of Payment, the vendor payment may be withheld in whole or in part until such time as compliance is achieved.

3. That this contract shall not be transferable or assignable.
4. That the parties further agree that any breach or violation of any provision of the contract shall make this entire contract subject to immediate cancellation.
5. That as the Agency amends, modifies or changes, in accordance with law the Standards for Payment, it shall immediately furnish the provider a copy of any such changes and that the Provider shall accept such amendment, modification or change by acknowledgement by the Provider shall become incorporated by references receipt thereof; such signed acknowledgement by the Provider shall become incorporated by references as a part of this contact, and the failure of the Provider to execute and return the acknowledgement to the Agency may, at the Agency's option, serve as sufficient justification for termination of this contract.
6. That this contract may be renewed and extended in accordance with the terms if any future certification for participation which may be made by the Agency, and such renewal or extension may be made by written notice to the Provider in the form of a letter from which the contract is to be renewed or extended; and each of such letters or renewal shall be incorporated into and become a part of this contract.  
Said amendment of the Standards for Payment shall become effective upon the date that Provider signs the acknowledgement.
7. The parties hereto mutually agree that this agreement shall be effective the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
**Print the Name of the Authorized Representative**

\_\_\_\_\_  
**Title / Position of Authorized Representative**

\_\_\_\_\_  
**Signature of Authorized Representative**

\_\_\_\_\_  
**Date of Signature**

**Addendum to Provider Agreement**  
**For**

- Skilled Nursing/Technology Dependent Care (SN/TDC) (Rate 4)**
- Skilled Nursing/Infectious Diseases (SN/ID) (Rate 5)**
- Nursing Facility/Neurological Rehabilitation Treatment Program (NF/NRTP)**
- Nursing Facility/Rehabilitation Services (Rate 6)**
- Nursing Facility/Complex Care (Rate 7)**

**IN THE STATE OF LOUISIANA MEDICAID PROGRAM – TITLE XIX**

This addendum is a supplement to a valid provider agreement for Nursing Facility services in the Louisiana State Medical Assistance Program (Title XIX) and provider agrees to adhere to all rules, regulations and conditions which are outlined in the aforementioned instrument.

This contract has been entered into by and between the State of Louisiana through the Department of Health and Hospitals hereinafter referred to as Agency, and \_\_\_\_\_ d/b/a \_\_\_\_\_, hereinafter referred to as Provider, located at \_\_\_\_\_, Louisiana, represented by \_\_\_\_\_, Owner and/or Authorized Representative. Provider agrees to meet the specific requirements outlined as follows:

- 1) Reimbursements for these services shall be subject to established payment limitations, standards for participation, and standards for payment and all additional requirements for provision of services indicated above
- 2) The facility may have entered into a contractual agreement with the bureau to begin providing the required services
- 3) The facility must be licensed to provide Nursing Facility services
- 4) The facility must have a valid Title XIX provider agreement for provision of Nursing Facility services
- 5) A For SN/ID and SN/TDC, the following applies: At the end of each 12-month period, the facility shall file a supplemental long-term facility cost report that shall be subject to audit.  
B For NF/NRTP, the following applies: At the end of each 12-month period, the facility shall file a separate standard long-term facility cost report and/or any additional cost reporting documents as required by the Department that shall be subject to audit

IN WITNESS WHEREOF, this agreement is signed and entered into on the day below indicated

\_\_\_\_\_  
**Print the Name of the Authorized Representative**

\_\_\_\_\_  
**Title / Position of Authorized Representative**

\_\_\_\_\_  
**Signature of Authorized Representative**

\_\_\_\_\_  
**Date of Signature**