PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid)

Office of Aging and Adult Services Organized Health Care Delivery System

(Enrollment packet is subject to change without notice)

PROVIDER AGREEMENT BETWEEN
THE LOUISIANA OFFICE OF AGING AND ADULT SERVICES AND
AN ORGANIZED HEALTH CARE DELIVERY SYSTEM

The Organized Health Care Delivery System agency must complete the following prior to enrolling with Medicaid. Medicaid Provider Enrollment will not process your enrollment packet until your agency has completed the following Office of Aging and Adult services (OAAS) requirements in the order listed below:

- Provide to OAAS the "OAAS Organized Health Care Delivery System Provider Agreement" (*i.e.,* the original signed form).

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 Organized Health Care Delivery System as instructed.

Any questions regarding the Medicaid Enrollment packet should be submitted to Gainwell 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.

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

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 Gainwell 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 the Organized Health Care Delivery System being incorrectly listed on the freedom of choice list.

Providers enrolled as type SP (OAAS Organized Health Care Delivery System) may subcontract with appropriate entities who will provide waiver services in accordance with applicable rules, regulations and policies to recipients of OAAS Community Choices Waiver. These subcontracted entities must accept payment from Organized Health Care Delivery System as payment in full for services rendered. Louisiana Medicaid will not increase reimbursement to the Organized Health Care Delivery System for any reason.

NOTICE TO WAIVER SERVICE PROVIDERS

Please note that Louisiana 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

OAAS Organized Health Care Delivery System
CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Gainwell Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Office of Aging and Adult Services (OAAS) Organized Health Care Delivery System provider:

Completed	Document Name
☐ *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
☐ *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	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.)** **Option 1**prefer: 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. **-or-** **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.
☐ *	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).
☐	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**).
☐	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**).
☐ **	8. Original signed copy of the Organized Health Care Delivery System (OHCDS)Provider Agreement

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

**This form is 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:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

OFFICE OF AGING AND ADULT SERVICES (OAAS) ORGANZIED HEALTH CARE DELIVERY SYSTEM AGREEMENT

_____

(Name of Organized Health Care Delivery System)

1. PURPOSE

The Office of Aging and Adult Services (OAAS) Organized Health Care Delivery System Agreement, hereafter referred to as the AGREEMENT, is an addendum to the Louisiana Medicaid Provider Enrollment Packet (PTSP). OAAS reserves the right to revise and reissue the AGREEMENT as deemed necessary. The purpose of the AGREEMENT is to ensure that the Organized Health Care Delivery System, hereinafter referred to as the OHCDS, shall provide waiver services in accordance with applicable federal and state regulations, rules, policies, procedures, manuals, memoranda, and standards; and, in order to receive reimbursement for the provision of such services, a fully-executed version of the AGREEMENT between the OHCDS and the Office of Aging and Adult Services, hereafter referred to as OAAS, shall be in place.

2. AUTHORITY

The following documents are considered as the Authority under which the OHCDS must conduct its activities under the AGREEMENT: All applicable Rules, Standards, Statutes, Regulations, Memoranda, and directives from OAAS.

While OAAS will make every effort to inform the OHCDS 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 OHCDS 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.

3. PARTICIPATION

By submitting this application, the OHCDS seeks designation to sub-contract with qualified providers for approved services for individuals served through the Department of Health and Hospital's Community Choices Waiver. The OHCDS hereby attests that:

- it provides at least one Medicaid service directly (i.e., with its own employees) using provider number_____

- either through using its own employees or through sub-contracts, that it must provide all of the following Community Choices Waiver Services:

  Personal Assistance Services (PAS)

  Home Delivered Meals

  Skilled Maintenance Therapy

  Nursing

  Caregiver Temporary Support Services

  Assistive Devices and Medical Supplies

  Environmental Accessibility Adaptations (EAA)

  Adult Day Health Care (if there is a licensed Adult Day Health Care provider in the service area)

- all sub-contracts contain a sign-off clause stating that the sub-contractor understands that the sub-contractor has the option of becoming a qualified Community Choices Waiver provider by enrolling directly with Louisiana Medicaid

- each provider it sub-contracts with meets the applicable qualifications and standards for the waiver service it intends to provide as specified in the Community Choices Waiver document/application, with the exception of enrollment as a Medicaid service provider

- it shall maintain necessary documentation to ensure that each provider it sub-contracts with meets the applicable qualifications and standards for the waiver service it intends to provide as specified in the Community Choices Waiver document

4. PAYMENTS TO OHCDS

The OHCDS shall submit claims for waiver services in accordance with instructions issued by the Department. The OHCDS shall be responsible for the accuracy of all claims submitted under its provider number, whether submitted by the OHCDS or on behalf of the OHCDS. The OHCDS shall timely reimburse its sub-contractors for services rendered. The OHCDS shall accept the waiver payment as payment in full for the service rendered and shall not seek any additional payment from a waiver participant under any circumstances.

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

OHCDS 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. The OHCDS shall not bill or receive payment for services that are not authorized in a plan of care. The OHCDS acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions, including exclusion of participation in Medicare, the Louisiana Medical Assistance Program, other State Medicaid programs, and all other Federal and State health care programs.

6. FREEDOM OF CHOICE/PLAN OF CARE REQUIREMENTS

The OHCDS shall ensure that all waiver services it provides directly or through its sub-contractors are provided in accordance with the plan of care and shall ensure that each waiver participant has a free choice of enrolled Community Choices Waiver providers for the services the waiver participant is authorized to receive.

7. REPORTING REQUIREMENTS

The OHCDS shall submit, in addition to all other required reports and statements, an aggregate summary delineating OHCDS activities, including subcontractor names, amounts paid per contractor, type of services delivered, and number of persons served by each subcontractor. This report shall be due to OAAS on a monthly basis in a manner and format prior-approved by OAAS.

8. 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 OHCDS shall comply with the AGREEMENT. Should the OHCDS be determined to be in violation, OAAS/Medicaid reserves the right to impose Sanctions on the OHCDS, 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
- Imposition of training and accountability measures
- Imposition of further performance requirements
- Placing moratorium on admissions and/or expansion of services (i.e. Removal from FOC list)
- Removal of existing participants. If OAAS determines that removal of existing participants is necessary, the OHCDS shall cooperate in the transfer of the participants to other provider agencies or face additional sanctions.

In addition to the measures described above, sanctions may also include, but are not limited to, the following, which are subject to an administrative appeal:

- Suspension of payments in whole or part for a specific time period Recoupment
- Denial of reimbursement for undocumented services Impose daily, weekly, or monthly fines
- Imposition of fines per day per incident for health and welfare issues Certification suspension/limitation/revocation
- Termination of the Performance Agreement /Provider Agreement

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

In addition, any OHCDS 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.

9. APPEALS

Specified Sanctions administered by OAAS in accordance with the AGREEMENT may be appealed by the OHCDS, and the OHCDS 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-Health and Hospitals Section
P.O. Box 4189
Baton Rouge, LA 70821 Telephone: 225-342-5800
Fax: 225-219-9823

I attest that _____ shall abide by the stipulations above
(Name of OHCDS)

and shall notify OAAS immediately of any changes and shall abide by any additional other relevant governing authority.

_____ _____
(Printed Name) (Title – CEO or Board President)

_____ _____
(Signature of OHCDS Representative) (Date)

APPENDIX A:

OFFICE OF AGING AND ADULT SERVICES (OAAS) ORGANZIED HEALTH CARE DELIVERY SYSTEM AGREEMENT

_____
(Name of Organized Health Care Delivery System)

Name of Sub-Contracted Provider:

_____

Contact Person for Sub-Contracted Provider: **Phone Number:**

_____ _____

Mailing Address of Sub-Contracted Provider:

_____

Physical Address of Sub-Contracted Provider: **(Same as Mailing Address ☐)**

_____

☐ **Completed Sub-Contract(s) attached.**

Community Choices Waiver service(s) provided:

1. _____
2. _____
3. _____
4. _____

APPENDIX B:

OFFICE OF AGING AND ADULT SERVICES (OAAS) ORGANZIED HEALTH CARE DELIVERY SYSTEM AGREEMENT

_____
(Name of Organized Health Care Delivery System)

Name of Sub-Contracted Provider:

_____

Contact Person for Sub-Contracted Provider: **Phone Number:**

_____ _____

Mailing Address of Sub-Contracted Provider:

_____

Physical Address of Sub-Contracted Provider: **(Same as Mailing Address ☐)**

_____

☐ **Completed Sub-Contract(s) attached.**

Community Choices Waiver service(s) provided:

1. **_____**

2. **_____**

3. **_____**

4. **_____**

APPENDIX C:

OFFICE OF AGING AND ADULT SERVICES (OAAS) ORGANZIED HEALTH CARE DELIVERY SYSTEM AGREEMENT

_____
(Name of Organized Health Care Delivery System)

Name of Sub-Contracted Provider:

_____

Contact Person for Sub-Contracted Provider: **Phone Number:**

_____ _____

Mailing Address of Sub-Contracted Provider:

_____

Physical Address of Sub-Contracted Provider: **(Same as Mailing Address ☐)**

_____

☐ **Completed Sub-Contract(s) attached.**

Community Choices Waiver service(s) provided:

1. _____
2. _____
3. _____
4. _____