



State of Louisiana
Louisiana Department of Health
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

November 21, 2016

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

**RE: LA SPA TN 16-0013 RAI Response
Personal Care Services – Long Term (LaPOP) Termination**

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 16-0013 with the proposed effective date of April 20, 2016. The State Plan amendment (SPA) proposes to amend the provisions governing long-term personal care services (LT-PCS) in order to: 1) terminate the Louisiana Personal Options program (LaPOP); 2) revise the eligibility requirements for shared LT-PCS; and 3) clarify the provisions governing the activities of daily living. We are providing the following in response to your request for additional information (RAI) dated August 31, 2016.

Appendix 1 to Attachment 3.1A, Item 26, Pages 1- 6 Personal Care Services

1. Eligibility Criteria, page 2

SSA §1902(a)(10)(B) requires that services made available to any eligible individual not be less in amount, duration, or scope than the services made available to any other eligible individual. 42 CFR §440.167 provides that personal care services may be furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, or institution for mental diseases. Please remove the following language from the plan page:

Eligibility Criteria

Personal care services shall be available to recipients who are 65 years of age or older, or 21 years of age or older and have a disability. Persons with a disability must meet the disability criteria established by the Social Security Administration.

RESPONSE:

Please see revisions to Attachment 3.1-A, page 2.

The prohibition on personal representatives is already appropriately stated on page 1 under worker qualifications. Please remove the language in the second eligibility criteria paragraph:

Persons designated as the personal representative of an individual receiving services under Long Term-Personal Care Services (LT-PCS) may not be the paid direct service worker of the individual they are representing.

RESPONSE:

Please see revisions to Attachment 3.1-A, page 2.

2. Covered Services, page 2

PCS services are defined as assistance with ADL & IDL. ADLs includePlease explain the intent of the language that excludes getting on and off a toilet and in and out of a tub/shower from the scope of transferring. Is the idea that these tasks are inherent in toileting and bathing, respectively?

RESPONSE:

The Minimum Data Set-Home Care (MDS-HC) assessment tool used to assess individuals for services, covers getting on and off the toilet under the “toilet use” activity of daily living (ADL). It also assesses the “bathing” ADL where getting in and out of the tub is assessed. The “transferring” ADL covers moving between surfaces such as from the bed to a chair or a sofa, or going from a sitting to a standing position. The intent is that all three ADLs are assessed under these separate areas with no duplication of level of assistance.

3. Covered Services, page 3

Please change, “Emergency and nonemergency medical transportation is a covered Medicaid service” to “Emergency and nonemergency medical transportation are separate covered Medicaid services”.

Please remove, “If transportation is furnished, the participant must accept all liability for their employee transporting them.” Recipients are not employers.

Please move, “It is the responsibility of the provider agency to ensure that the employee has a current, valid driver’s license and automobile liability insurance.” to the section on provider qualifications.

RESPONSE:

The changes have been made. Please see Attachment 3.1-A, pages 1 and 3.

4. Please remove, "For recipients receiving LT-PCS with the Adult Day Health Care (ADHC) Waiver, personal care services may be provided by one worker for up to three LT-PCS service recipients who live together, and who have a common direct service provider." This language is not related to defining the PCS benefit. Also, please remember that in accordance with 42 CFR 431.51, individuals must have free choice of provider.

RESPONSE:

The language has been removed. Please see Attachment 3.1-A, pages 3 and 4.

5. Service Limitations, page 4
42 CFR § 440.230(b) provides that each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. Is the 32-hour per week limit a hard limit? Is it possible to exceed the 32 hours if determined to be medically necessary? If the limitations cannot be exceeded based on medical necessity, the state will need to submit data to show that the limitation is sufficient to meet the needs of the population being served. Please see ATTACHMENT for questions to be answered and the accompanying data to be submitted.

RESPONSE:

Yes, the 32-hours per week is a hard limit and it cannot be exceeded. This service limit was previously approved by CMS and was effective in September 2010. If the participant feels that 32 hours is not enough to safely remain in the home, he/she may apply for an expedited Community Choices Waiver slot. This waiver would provide personal assistance and other services to support the individual in his/her home.

6. Employment Support, page 5
Is Employment Support different than the PCS services described on pages 1-4? If yes, please explain the difference.
Please explain if the 32-hour per week limit is a hard limit, or if 32 hours may be exceeded as medically necessary? Is this in addition to the general service limitations of 32 hour per week?

RESPONSE:

Yes, Employment Support was a separate approved service; however, the State chose not to implement it. The language has been removed from the State Plan.

Supplement 2 to Attachment 3.1-A, pages 1-16 1915 (j) Self Directed Personal Assistance Services

7. The state is eliminating the 1915(j) service delivery option and has provided public

notice and tribal notice. In addition to public notice, have individuals using this delivery option been directly notified of the program changes? Will individuals be able to retain their PAS worker under the traditional service delivery model?

RESPONSE:

The State did not have any individuals receiving this delivery option.

8. Supplement 2 to Attachment 3.1-A, pages 1-16, are being deleted; the pages should be submitted marked “intentionally left blank”.

RESPONSE:

Please see attached revised Supplement 2 to Attachment 3.1-A, Pages 1-18.

Attachment 4.19B, Item 26, Page 1

Personal Care Services/Unit of Reimbursement

9. The state indicates that there will not be any additional reimbursement for providing transportation. Will the provider be able to bill for the additional time to transport as part of the personal care service? Please explain.

RESPONSE:

Long Term-Personal Care Services (LT-PCS) assist recipients with accessing transportation. While emergency and non-emergency medical transportation is a covered Medicaid service and is available to all recipients, non-medical transportation is not a required component of LT-PCS. If transportation is provided during the course of LT-PCS by the provider, the time is billable.

10. The State has removed the maximum of 42 hours per week personal care. Is there no longer a maximum limit? Please explain.

RESPONSE:

Please see revision to Attachment 4.19-B, Item 26, Page 1. The 42 hours listed in the attachment should have been revised in accordance with the 2010 rule and subsequent SPA, LA SPA TN 10-53 (approved December 14, 2010), which reduced the maximum to 32 hours per week. The State has made the correction in Attachment 4.19-B, Item 26, Page 1. The current maximum of 32 hours per week is correct in Attachment 3.1-A for personal care services.

11. The State has added language that “the minimum hourly rate paid to personal care workers shall be at least the current federal minimum hourly rate”. This is not a comprehensive methodology. Please add an effective date and include language that states that should a change in the federal minimum hourly rate result in a rate that is above the minimum hourly rate paid to personal care workers, the minimum hourly rate paid to personal care workers will adjust to the federal minimum hourly rate the date that federal rate becomes effective.

RESPONSE:

Please see revisions to Attachment 4.19-B, Item 26, Pages 1 and 1a.

Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

12. Section 1903(a)(1) of the Social Security Act (the Act) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

RESPONSE:

Providers will receive and retain 100 percent of the payments. No portion of the payments is returned to the State.

13. Section 1902(a)(2) of the Act provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non- federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to

verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 Code of Federal Regulations (CFR) 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority: and
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

RESPONSE:

The State share is paid from the State general fund which is directly appropriated to the Medicaid agency.

14. Section 1902(a)(30) of the Act requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) of the Act provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

RESPONSE:

This SPA does not involve supplemental or enhanced payments.

15. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

RESPONSE:

Not applicable to this State Plan amendment.

16. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

RESPONSE:

The State does not have any public/governmental providers receiving payments that exceed their reasonable costs of services provided.

ATTACHMENT

17. **Background:** What is the reason for this limitation? If the reason for the limitation is duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning. What other approaches/initiatives/processes have you tried or considered to address this matter?

RESPONSE:

The reduction to a maximum of 32 hours was not based on duplication of services, abuse or inappropriate utilization. The service was capped due to budget constraints. Capping the program allowed the State to continue providing LT-PCS to an increasing number of participants.

18. **Purpose:** What is the clinical purpose of this benefit and will that purpose be achieved even with this limit?

RESPONSE:

The LT-PCS program provides help with activities of daily living to individuals who qualify for assistance under the program guidelines. The program provides an alternative to nursing facility care and allows individuals to maintain their independence in the community. The rates of transition from the LT-PCS program to a nursing facility remain low even after the reduction from a 42 hour maximum to a 32 hour maximum. The rate of transition measured quarterly has remained stable at approximately two percent.

19. **Data Support- Existing:** With respect to existing limitations and using data within the last 12 months, what percentage of Medicaid beneficiaries utilized the maximum amount of the service? Please provide this information for the following eligibility groups:
- Aged, Blind and Disabled;
 - Non-Dually Eligible Adults (for analyses of services for which Medicare would not be primary payer, otherwise the analysis would include dually eligible individuals);
 - Pregnant Women;
 - Parents/Caretakers /Other Non-Disabled Adults;
 - Adult expansion group, if applicable

RESPONSE:

- | | |
|---|---------------------|
| a. Aged, Blind and Disabled | 0.12 percent |
| b. Non-Dually Eligible Adults (for analyses of services for which Medicare would not be primary payer, otherwise the analysis would include dually eligible individuals) | 0.02 percent |
| c. Pregnant Women | 0 percent |
| d. Parents/Caretakers /Other Non-Disabled Adults | 0 percent |

e. **Adult expansion group, if applicable**

Not applicable

20. **Clinical Support:** If the data requested above is not available, or is not relevant to demonstrating the sufficiency of the limited benefit, please indicate support for this proposed scope of services through clinical literature or evidence-based practice guidelines, or describe your consultation with your provider community or others that resulted in an assurance that this proposed scope of services has meaningful clinical merit to achieve its intended purpose.

RESPONSE:

Please see response to question 19.

21. **Exceptions:** Are there any exemptions to the proposed limitations? If so, how was this exemption determined to be appropriate? Does the state have a process for granting other exemptions if similar circumstances warrant? (e.g., if there is an exemption for individuals with one condition because their needs are greater, is there a process for other individuals with conditions that result in greater needs to request an exemption?) Can additional services beyond the proposed limit be provided based on a determination of medical necessity? That is, will there be an exception or prior authorization process for beneficiaries that require services beyond the limitation?

RESPONSE:

There is no exemption to the 32 hour limitation. There is no exception or prior authorization process for beneficiaries that require services beyond the 32 hour limitation; however, if the participant feels that 32 hours is not enough to safely remain in the home, he/she may apply for an expedited Community Choices Waiver slot. This waiver would provide for personal assistance and other services to support the individual in his/her home.

22. **Beneficiary Impact:** Please describe what will or is likely to occur to beneficiaries who will be impacted by this limitation. If the limit cannot be exceeded based on a determination of medical necessity:
- How will those affected by the limitation obtain the medical services they need beyond the stated limits?
 - Will beneficiaries be billed and expected to pay for any care that may not be covered? Or, instead will the provider or practitioner be expected to absorb the costs of the provided services?
 - Will beneficiaries be reassessed to determine need for the service prior to the plan amendment's effective date?
 - If the beneficiary's covered services are being reduced, will the beneficiary be notified of their appeals rights per 42 CFR 431.206?

RESPONSE:

- a. If the participant feels that 32 hours is not enough to safely remain in the home, he/she may apply for an expedited Community Choices Waiver slot. This waiver would provide for personal assistance and other services to support the individual in his/her home.
- b. The provider is only expected to provide services approved in the beneficiaries plan of care. No other services are expected to be provided or will be paid for by Medicaid.
- c. Beneficiaries are assessed at least every 18 months or upon a status change.
- d. The 32 hour maximum is currently in place. No one will have service reductions as a result of this amendment.

23. **Tracking:** How will the limitation be tracked? Will both providers and beneficiaries be informed in advance so they know they have reached the limit? Please summarize the process.

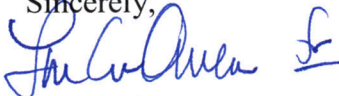
RESPONSE:

The limit is tracked through prior and post authorization processes. The provider is notified of the prior authorized amount. The Medicaid data management contractor tracks the amount of services reported by the provider and post-authorized for payment. The provider is not able to bill for units in excess of those authorized.

Please consider this a formal request to begin the 90-day clock. We trust this additional information will result in the approval of the pending SPA. We look forward to negotiating with CMS to ensure approval.

As always, we appreciate the assistance of Cheryl Rupley in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone at (225) 342-3881.

Sincerely,



Jen Steele
Medicaid Director

JS:DAB:JH

Attachments (2)

c: Darlene Budgewater
Cheryl Rupley
Tamara Sampson

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

~~16-0002~~ **16-0013**

2. STATE

Louisiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

April 20, 2016

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

**42 CFR 440.167 & 42 CFR 447 Subpart B
1915(j) of the Social Security Act**

7. FEDERAL BUDGET IMPACT:

a. FFY **2016** **\$0**

b. FFY **2017** **\$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 3.1-A, Item 26, Pages 1, 3, ~~5~~ and ~~6~~
Attachment 3.1-A, Item 26, Page 2
Attachment 3.1-A, Item 26, Page 4
Attachment 4.19-B, Item 26, Page 1
Attachment 4.19-B, Item 26, Page 1a
Attachment 4.19-B, Item 26, Page 1b (Remove page)
Attachment 4.19-B, Item 26, Page 4
Attachment 4.19-B, Item 28, Page 1
Supplement 2 to Attachment 3.1-A, Pages 1 through ~~16~~ **18**
Attachment 3.1-A, Item 26, Pages ~~5~~ and ~~6~~**

9. PAGE NUMBER OF THE SUPERSEDED PLAN
SECTION OR ATTACHMENT (If Applicable):

**Same (TN 10-53)
Same (TN 15-0003)
Same (TN 03-32)
Same (TN 12-23)
None – New Page
Same (TN 10-48)
Same (TN 03-32)
Same (TN 08-25) Reserved
Same (TN 08-25) Removed Intentionally left blank
Same (TN 10-53) Removed**

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing long-term personal care services (LT-PCS) in order to 1) terminate the Louisiana Personal Options Program (La POP); 2) revise the eligibility requirements for shared LT-PCS; and 3) clarify the provisions governing the activities of daily living.**

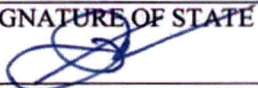
11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Rebekah E. Gee MD, MPH

14. TITLE:

Secretary

15. DATE SUBMITTED:

June 6, 2016

16. RETURN TO:

**Jen Steele, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: **The State requests a pen and ink change to boxes 8 and 9, as indicated above.**

STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL
AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

Medical and Remedial Care and Services
42 CFR 440.167

Personal Care Services

Definition

Personal care services are defined as services furnished to an individual who is not an inpatient, or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, or an institution for mental disease that are authorized for the individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a service plan approved by the State; provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and furnished in a home, and at the state's option, in another location.

Personal care services enable an individual whose needs would otherwise require placement in an acute or long term care facility to remain safely in that individual's home. Services must be provided in accordance with an approved plan of care and supporting documentation. These services must be coordinated with other Medicaid services being provided to the recipient and will be considered in conjunction with those other services.

Personal Care Services Worker Qualifications:

1. The worker must be at least 18 years of age at the time the offer of employment is made.
2. The worker must meet one of the following minimum education and experience qualifications:
 - a. a high school diploma or general equivalency diploma (GED); or
 - b. a trade school diploma in the area of human services; or
 - c. documented, verifiable experience providing direct care services to the elderly and/or persons with disabilities.
3. The worker must have the ability to read and write in English as well as to carry out directions promptly and accurately.
4. If transportation is furnished, the provider must accept all liability for their employee transporting them. It is the responsibility of the provider agency to ensure that the employee has a current, valid driver's license and automobile liability insurance.

STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL
AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

The following persons are prohibited from serving as the direct service worker for the recipient: the recipient's spouse, curator, tutor, legal guardian, recipient's responsible representative, or person to whom the recipient has given Representative and Mandate authority (Power of Attorney). The Bureau has in place mechanisms to monitor the quality of the services provided. These include, but are not limited to, review of critical incident reports and quarterly meetings to review and address any quality assurance issues that have been identified.

Assessment

An initial assessment shall be performed for each recipient requesting personal care services. The assessment shall be utilized to identify the recipient's long term care needs, preferences, the availability of family and community supports and to develop the plan of care. Each recipient shall be re-assessed at least once every 18 months.

Prior Authorization

Personal care services must be prior authorized. Requests for prior authorization must be submitted to the Bureau of Health Services Financing (BHSF) or its designee and include a copy of the assessment form and the plan of care.

Covered Services

Personal care services are defined as those services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs). Assistance may be either the actual performance of the personal care task for the individual or prompting and reminding so the individual performs the task by him/herself.

ADLs are those personal, functional activities required by the recipient. ADLs include tasks such as: eating, bathing, dressing, grooming, transferring (the manner in which an individual moves from one surface to another - excludes getting on and off the toilet and getting in and out of the tub/shower), reminding the recipient to take medication, ambulation, toileting and bed mobility.

IADLs are those activities that are considered essential for sustaining the individual's health and safety, but may not require performance on a daily basis. IADLs include tasks such as: light housekeeping, food preparation and storage, grocery shopping, laundry, assisting with scheduling medical appointments when necessary, accompanying recipient to medical appointments when necessary due to recipient's frail condition and assisting the recipient to access transportation.

STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL
AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

Emergency and nonemergency medical transportation are separate covered Medicaid services; however, providers may choose to furnish transportation for recipients during the course of providing personal care services. (Please see personal assistance services worker qualifications.)

Personal care services for eligible children are described in Attachment 3.1-A, Item 4.b. EPSDT Services.

Service Delivery

Personal care services shall be provided in the recipient's home or in another location outside of the recipient's home if the provision of these services allows the recipient to participate in normal life activities pertaining to the IADLs cited in the plan of care. Place(s) of service must be documented in the plan of care and the service logs.

The recipient's home is defined as the recipient's place of residence including his/her own home or apartment, a boarding house, or the house or apartment of a family member or unpaid primary caregiver. A hospital, an institution for mental disease, a nursing facility or an intermediate care facility for persons with intellectual disabilities are not considered to be the recipient's home.

The provision of services outside of the recipient's home does not include trips outside of the borders of the state without approval of the Department's Office of Aging and Adult Services (OAAS) or its designee.

Recipients are not permitted to live in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services, and providers are prohibited from providing and billing for services under these circumstances. Recipients may not live in the home of a direct support worker unless the direct support worker is related by blood or marriage to the recipient.

STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL
AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

Service Limitations

Effective September 5, 2010, personal care services shall be limited to 32 hours per week. Authorization of service hours shall be considered on a case by case basis as substantiated by the recipient's plan and supporting documentation.

IADLs cannot be performed in the recipient's home when he/she is absent from the home.

There shall be no duplication of services.

Persons designated as the personal representative of an individual receiving services under Long Term-Personal Care Services (LT-PCS) may not be the paid direct service worker of the individual they are representing.

TN _____
Supersedes
TN _____

Approval Date _____

Effective Date _____

STATE OF LOUISIANA

PAYMENT OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Medical and Remedial Care and Services
42 CFR 447, Subpart B

Personal Care Services

Unit of Reimbursement

Reimbursement for personal care services shall be a prospective flat rate for each approved unit of service that is provided to the recipient. One quarter hour (15 minutes) is the standard unit of service for personal care services. Additional reimbursement shall not be paid for the provision of less than one quarter hour (15 minutes) of service. Additional reimbursement shall not be available for transportation furnished during the course of providing personal care services.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Medicaid Provider Website at www.lamedicaid.com.

Effective for dates of service on or after February 1, 2009, the reimbursement rate shall be reduced by 3.5 percent of the rate on file as of January 31, 2009.

Effective for dates of service on or after August 4, 2009, the reimbursement rate for long-term personal care services shall be reduced by 4.8 percent of the rate on file as of August 3, 2009.

Effective for services provided on or after July 21, 2010 for personal care services rendered in conjunction with the Pediatric Day Health Program, reimbursement is made pursuant to the methodology described on page 4.19-B, Item 4b, Page 5 under Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Pediatric Day Health Program.

Effective for dates of service on or after August 1, 2010, the reimbursement rate for long-term personal care services shall be reduced by 4.6 percent of the rate on file as of July 31, 2010.

Effective for dates of service on or after January 1, 2011, the reimbursement rate for long-term personal care services shall be reduced by 5.8 percent of the rate on file as of December 31, 2010.

STATE OF LOUISIANA

PAYMENT OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Effective for dates of service on or after July 1, 2012, the reimbursement rate for long-term personal care services furnished to one participant shall be reduced by 1.5 percent of the rate on file as of June 30, 2012.

Effective April 20, 2016, the minimum hourly rate paid to personal care workers shall be at least the current federal minimum hourly rate. Should a change in the federal minimum hourly rate result in a rate that is above the minimum hourly rate paid to personal care workers, the minimum hourly rate paid to personal care workers will adjust to the federal minimum hourly rate the date that federal rate becomes effective.

Standards for Payment

Providers shall comply with standards for participation established by the Bureau of Health Services Financing (BHSF).

NOTE: Prior authorization is required for personal care services.

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

10. have a written policy for an informal resolution process to address recipient complaints and/or concerns regarding personal assistant services; and
11. have a written policy for a formal resolution process to address those situations where the informal resolution process fails to resolve the recipient's complaint.

Note: Prior Authorization is required for personal assistant services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Attachment 4.19-B
Item 28, Page 1

STATE OF LOUISIANA

PAYMENT OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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