TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE
STATE PLAN MATERIAL	09-08	Louisiana
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	March 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One):	-	
□ NEW STATE PLAN □ AMENDMENT TO BE CONST		ENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEN	IDMENT (Separate Transmittal for each	amendment)
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.167	7. FEDERAL BUDGET IMPACT:	(# . 231 0.4)
42 CFR 440.167 42 CFR 447 Subpart B	a. FFY <u>2009</u> b. FFY <u>2010</u>	(<u>\$621.94)</u> (\$1,035.69)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN	
Atta-Tomont 2.1 A. T. A.C. D	SECTION OR ATTACHMENT (If Applicable): Same (TN 06-32)	
Attachment 3.1-A, Item 26, Page 1 Attachment 3.1-A, Item 26, Page 3	Same (TN 00-32) Same (TN 04-10) (TN 09-04)	
Attachment 4.19-B, Item 26, Page 1	Same (TN 06-32)	
Attachment 4.15-D, Rein 20, Page 1	Same (111 00-32)	
10. SUBJECT OF AMENDMENT: The purpose of this amend agreed to in the Barthelemy lawsuit settlement. 11. GOVERNOR'S REVIEW (Check One): ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	Ment is to implement cost-citects ✓ OTHER, AS SPECIFIED: The Governor does not review	
□ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL:		•
12. SIGNATUMBOF STATE AGENCY OFFICIAL:		
	State of Louisiana	
13. TYPED NAME:	Department of Health and Hospitals	
Alan Levine 14. TITLE:	628 N. 4 th Street	
Secretary	PO Box 91030	
15. DATE SUBMITTED:	Baton Rouge, LA 70821-9030	
March 3, 2009		
FOR REGIONAL OF	FICE USE ONLY	
17. DATE RECEIVED: 5 March, 2009	18. DATE APPROVED:	2009
PLAN APPROVED - ONE		
1 March 2009	0. SIGNATURE OF APOIONAL OFFICIAL:	
21. TYPED NAME: BILL Brooks	22. TITLE: Associate Kegic	ral Administrata É Phildrens Henl
23. REMARKS:	J. C. Francis	To 10
23. REMARKS: Pen + Ink Charge made per state's E-Mail Dated		
5-7-09		
5-7-09.	per states E-Mail	Vated

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:

Personal care services are medically necessary if the recipient:

- 1) Meets the medical standards for admission to a nursing facility, and requires assistance with at least one or more activities of daily living;
- 2) Is able, either independently or through a responsible representative, to participate in his/her care and self-direct services provided by the personal care services worker; and
- Faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community based services or nursing facility services are not provided. This criterion will be considered met if the recipient is in a nursing facility and could be discharged if community-based services were available; or requires nursing facility admission.

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

Place of Service

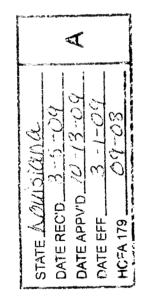
Personal care services may be provided in the recipient's home and in another location outside of the recipient's home if the provision of these services allows the recipient to participate in normal life activities pertaining to the IADLs cited in the plan of care. Place(s) of service must be documented 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 development disabilities are not considered to be the recipient's home.

Service Limitations

Effective March 1, 2009, personal care services shall be limited to up to 42 hours per week. Authorization of service hours shall be considered on a case by case basis as substantiated by the recipient's plan of care and supporting documentation.

SUPERSEDES: TN- 09-09



TN# <u>09-08</u> Supersedes TN# <u>09-04</u>

Attachment 4.19-B Item 26, Page 1

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

CTTATION Medical and Remedial 42 CFR 447 Care and Services Subpart B Item 26

Personal Care Services

Reimbursement Methodology

Reimbursement for personal care services is a prospective flat rate for each approved unit of service that is provided to the recipient. One quarter hour is the standard unit of service. Reimbursement shall not be authorized for the provision of less than one quarter of an hour of service. Effective March 1, 2009, personal care services cannot exceed 42 hours per week. 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 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.

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.

SUPERSEDES: TN 06-32

STATE LOUISIAN &

DATE REC'D. 3-5-09

DATE APPV'D 10-13-09

DATE EFF. 3-1-09

HCFA 179 09-08

TN # 09-08
Supersedes
TN # 06-32

Approval Date 10-13-09

Effective Date 3-1-09