

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

1. TRANSMITTAL NUMBER:

09-08

2. STATE

Louisiana

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

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

4. PROPOSED EFFECTIVE DATE

March 1, 2009

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

7. FEDERAL BUDGET IMPACT:

a. FFY 2009 (\$621.94)
b. FFY 2010 (\$1,035.69)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Item 26, Page 1
Attachment 3.1-A, Item 26, Page 3
Attachment 4.19-B, Item 26, Page 1

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 PAGE NUMBER OF THE SUPERSEDED PLAN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

~~Same (TN 06-32)~~
Same (~~TN 04-10~~) (TN 09-04)
Same (TN 06-32)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to implement cost-effectiveness measures as 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
 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:

Alan Levine

14. TITLE:

Secretary

15. DATE SUBMITTED:

March 3, 2009

16. RETURN TO:

State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

5 March, 2009

18. DATE APPROVED:

13 October, 2009

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

1 March 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

[Signature]

21. TYPED NAME:

Bill Brooks

22. TITLE: Associate Regional Administrator
Div of Medicaid & Children's Health

23. REMARKS:

* Pen + Ink Charge made per state's E-mail Dated 5-7-09.

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
- 3) 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, item 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.

A
STATE <u>Louisiana</u>
DATE REC'D <u>3-5-09</u>
DATE APP'VD <u>10-13-09</u>
DATE EFF <u>3-1-09</u>
HCFA 179 <u>09-08</u>

SUPERSEDES: TN 09-09

TN# 09-08
Supersedes
TN# 09-09

Approval Date 10-13-09 Effective Date 3-1-09

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:

CITATION 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

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