

2. services shall be limited to certain geographical areas.

C. The recipient may receive services on an inpatient or an outpatient basis and will not be forced under this provision to receive case management services for which he or she may be eligible. Providers of case management services under this provision will not be reimbursed for specific services provided to individuals in institutional settings when those services are included in the per diem rate for the institution.

D. Payment for case management services under this provision will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:479 (June 1989), amended LR 23:732 (June 1997), amended LR 25:1251 (July 1999), repromulgated for inclusion in LAC, LR 30:1043 (May 2004).

#### **§11903. Recipient Requirements**

A. Service will be reimbursed when provided to HIV disabled individuals subject to the provisions below.

1. The recipient must have reached, as documented by a physician, a level 70 on the Karnofsky scale at some time during the course of HIV infection.

2. The recipient must be unable to arrange the necessary services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:479 (June 1989), repromulgated for inclusion in LAC, LR 30:1043 (May 2004).

#### **§11905. Provider Requirements**

A. In addition to the requirements listed in §10501, the provider of case management services must:

1. have one or more documented years providing case management services to HIV disabled individuals;

2. sign a notarized letter of assurance that the requirements of Louisiana Medicaid will be met.

B. In order to be reimbursed by the state, the provider of case management must satisfactorily complete a one-day training approved by the department's HIV program office if serving HIV-infected individuals.

C. The individual assigned as the case manager shall maintain contact with the recipient or his/her legal representative and these contacts shall be documented in progress notes and address the efficacy of the care plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 15:479 (June 1989), amended LR 19:645 (May 1993), LR 23:732 (June 1997), repealed and promulgated LR 25:1251 (July 1999), repromulgated for inclusion in LAC, LR 30:1043 (May 2004).

## **Subpart 9. Personal Care Services**

### **Chapter 129. Long Term Care**

#### **§12901. General Provisions**

A. The purpose of personal care services is to assist individuals with functional impairments with their daily living activities. Personal care services must be provided in accordance with an approved service plan and supporting documentation. In addition, personal care services must be coordinated with the other Medicaid and non-Medicaid services being provided to the recipient and will be considered in conjunction with those other services.

B. Each recipient requesting or receiving long-term personal care services (LT-PCS) shall undergo a functional eligibility screening utilizing an eligibility screening tool called the level of care eligibility tool (LOCET), or a subsequent eligibility tool designated by the Office of Aging and Adult Services (OAAS).

C. Each LT-PCS applicant/recipient shall be assessed using a uniform assessment tool called the minimum data set-home care (MDS-HC) or a subsequent assessment tool designated by OAAS. The MDS-HC is designed to verify that an individual meets eligibility qualifications and to determine resource allocation while identifying his/her need for support in performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The MDS-HC assessment generates a score which measures the recipient's degree of self-performance of late-loss activities of daily living during the period just before the assessment.

1. The late-loss ADLs are eating, toileting, transferring and bed mobility. An individual's assessment will generate a score which is representative of the individual's degree of self-performance on these four late-loss ADLs.

D. Based on the applicant/recipient's uniform assessment score, he/she is assigned to a level of support category and is eligible for a set allocation of weekly service hours associated with that level.

1. If the applicant/recipient is allocated less than 32 hours per week and believes that he/she is entitled to more hours, the applicant/recipient or his/her responsible representative may request a fair hearing to appeal the decision.

2. The applicant/recipient may qualify for more hours if it can be demonstrated that:

a. one or more answers to the questions involving late-loss ADLs are incorrect as recorded on the assessment; or

b. he/she needs additional hours to avoid entering into a nursing facility.

E. Requests for personal care services shall be accepted from the following individuals:

1. a Medicaid recipient who wants to receive personal care services;

2. an individual who is legally responsible for a recipient who may be in need of personal care services; or

3. a responsible representative designated by the recipient to act on his/her behalf in requesting personal care services.

F. Each recipient who requests PCS has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without his/her involvement.

b. The written designation is valid until revoked by the recipient. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the recipient in the assessment, care plan development and service delivery processes; and

b. to aid the recipient in obtaining all necessary documentation for these processes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:911 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2577 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2450 (November 2009), LR 39:2506 (September 2013).

### **§12902. Participant Direction Option**

A. The Office of Aging and Adult Services implements a pilot program, the Louisiana Personal Options Program (La POP), which will allow recipients who receive long term personal care services (LT-PCS) to have the option of utilizing an alternative method to receive and manage their services. Recipients may direct and manage their own services by electing to participate in La POP, rather than accessing their services through a traditional personal care agency.

1. La POP shall be implemented through a phase-in process in Department of Health and Hospitals administrative regions designated by OAAS.

2. La POP participants will use a monthly budget allowance to manage their own personal care services. Some of the monthly allowance may be used to purchase items that increase a participant's independence or substitute for his/her dependence on human assistance.

B. Participants are required to use counseling and financial management services in order to assume responsibility for directing their services and managing their budget.

1. A financial management agency is utilized to provide financial management and payroll services to La POP participants.

2. With the assistance of a services consultant, participants develop a personal support plan based on their approved plan of care and choose the individuals they wish to hire to provide the services.

C. An orientation to the Louisiana Personal Options Program, including participant roles and responsibilities, is required for all participants prior to the completion of enrollment in the program. The intent of the orientation is to provide participants with a program handbook and other tools they need to effectively and safely manage their services.

D. La POP participants may elect to discontinue participation in the program at any time. The services consultant must be notified and will begin the disenrollment process within five business days from the date of notification. A face-to-face meeting may be required if the individual remains eligible for long-term personal care services.

1. La POP services will continue until the transition to services provided by a personal care agency is completed.

2. Once disenrolled from La POP, the participant must continue to receive services through a traditional personal care services agency for a minimum of three months before re-enrollment in La POP can be considered.

E. La POP participants may be involuntarily disenrolled from the program for any of the following reasons.

1. Health, Safety and Well-being. The Office of Aging and Adult Services or its designee makes a determination that the health, safety and well-being of a participant is compromised or threatened by continued participation in La POP.

2. Change in Condition. The participant's ability to direct his/her own care diminishes to a point where he/she can no longer do so and there is no responsible representative available to direct the care.

3. Misuse of Monthly Allocation of Funds. The La POP participant or his/her responsible representative uses the monthly budgeted funds to purchase items unrelated to personal care needs or otherwise misappropriate the funds.