Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

June 19, 2014

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: Louisiana Title XIX State Plan
Transmittal No. 14-26

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material. I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,

Approved for

Kathy H. Kliebert
Secretary

Attachments (1)

KHK/JRK/DA

Bienville Building • 628 North 4th Street • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone #: 225/342-9509 • Fax #: 225/342-5568 • *WWW.DHH.LA.GOV*
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-26**

2. STATE: **Louisiana**

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: **June 1, 2014**

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 441 Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 ($114.40)
b. FFY 2015 ($347.97)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1A, Item 4.b. Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 07-06)

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) personal care services in order to revise the recipient qualifications to remove the criteria regarding parental/caregiver availability in the home.**

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: Approved for

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
June 19, 2014

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
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:

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:

FORM HCFA-179 (07-92)

LOUISIANA TITLE XIX STATE PLAN
TRANSMITTAL #: 14-26
TITLE: 14-26 EPSDT-PCS-Removal of Parental Responsibility
EFFECTIVE DATE: June 1, 2014

FISCAL IMPACT:
Decrease

	year	% inc.		fed. match	*# mos	range of mos.	dollars
1st SFY	2014			62.11%	1	June 1, 2014 - June 30,2014	($45,034)
2nd SFY	2015	3.0%		62.05%	12	July 2014 - June 2015	($556,620)
3rd SFY	2016	3.0%		62.05%	12	July 2015 - June 2016	($573,319)

*#mos-Months remaining in fiscal year

Total Decrease in Cost FFY **2014**

SFY	2014	($45,034)	for	1	months	June 1, 2014 - June 30,2014			($45,034)
SFY	2015	($556,620)	for	12	months	July 2014 - June 2015			
		($556,620) /		12 X	3	July 2014 - September 2014		=	($139,155)
									($184,189)
		FFP (FFY 2014) =				($184,189)	X	62.11% =	($114,400)

Total Decrease in Cost FFY **2015**

SFY	2015	($556,620)	for	12	months	July 2014 - June 2015			
		($556,620) /		12 X	9	October 2014 - June 2015		=	($417,465)
SFY	2016	($573,319)	for	12	months	July 2015 - June 2016			
		($573,319) /		12 X	3	July 2015 - September 2015		=	($143,330)
									($560,795)
		FFP (FFY 2015)=				($560,795)	X	62.05% =	($347,973)

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:

a. EPSDT Personal Care Services shall be prior authorized by the BHSF or its designee.

b. EPSDT Personal Care Services shall be provided in the recipient's home (defined as the recipient's own dwelling such as an apartment, a custodial relative's home, a boarding home, a foster home, a substitute family home) or, if medically necessary, in another location outside of the recipient's home such as a supervised living facility; these services are provided in a school setting only to the extent they do not duplicate services that must be provided by or are provided by the Department of Education.

c. Personal Care Services shall be authorized only when provided by a licensed Personal Care Service (PCS) agency which is duly enrolled as a Medical provider. Staff assigned to provide personal care services to a recipient shall not be a member of the recipient's immediate family. (Immediate family includes father, mother, sister/brother, spouse, child, grandparent, in-law or any individual acting as parent or guardian of the recipient.). Personal Care Services may be provided by a person of a degree of relationship to the recipient other than immediate family if the relative is not living in the recipient's home or if he/she is living in the recipient's home solely because his/her presence in the home is necessitated by the amount of care required by the recipient. EPSDT PCS shall not be authorized as a substitute for child care arrangements.