Personal Care Services

Personal care services (PCS) include assistance and/or supervision necessary for members with mental illness to enable them to accomplish routine tasks and live independently in their own homes.

Components

Personal care services include the following:

1. Minimal assistance with, supervision of, or prompting the member to perform **activities of daily living (ADLs)** including eating, bathing, grooming/personal hygiene, dressing, transferring, ambulation, and toileting;

2. Assistance with, or supervision of, **instrumental activities of daily living (IADLs)** to meet the direct needs of the member (and not the needs of the member's household), which includes:

    a. Light housekeeping, including ensuring pathways are free from obstructions;

    b. Laundry of the member's bedding and clothing, including ironing;

    c. Food preparation and storage;

    d. Assistance with scheduling (making contacts and coordinating) medical appointments;

    e. Assistance with arranging transportation depending on the needs and preferences of the member;

    f. Accompanying the member to medical and behavioral health appointments and providing assistance throughout the appointment;

    g. Accompanying the member to community activities and providing assistance throughout the activity;

h. Brief occasional trips outside the home by the direct service worker on behalf of the member (without the member present) to include shopping to meet the health care or nutritional needs of the member or payment of bills if no other arrangements are possible and/or the member's condition significantly limits participation in these activities; and

i. Medication reminders with self-administered prescription and non-prescription medication that is limited to:

i. Verbal reminders;

ii. Assistance with opening the bottle or bubble pack when requested by the member;

iii. Reading the directions from the label;

iv. Checking the dosage according to the label directions; or

v. Assistance with ordering medication from the drug store.

NOTE: PCS workers are NOT permitted to give medication to members. This includes taking medication out of the bottle to set up pill organizers.

3. Assistance with performing basic therapeutic physical health interventions to increase functional abilities for maximum independence in performing activities of daily living, such as range of motion exercise, as instructed by licensed physical or occupational therapists, or by a registered nurse.

Eligibility Criteria

Medicaid eligible members who meet medical necessity criteria may receive PCS when recommended by the member's treating licensed mental health professional (LMHP) or physician within their scope of practice. Members must be at least 21 years of age and have transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program. Members must be medically stable, not enrolled in a Medicaid-funded program which offers a personal care service or related benefit or receiving Long Term Personal

Care Services (LT-PCS), and whose care needs do not exceed that which can be provided under the scope and/or service limitations of this personal care service.

Service Utilization

Services require prior authorization. Providers shall submit sufficient documentation to determine medical necessity. Failure to do so may result in a partial or non-authorization for services.

Service Delivery

There shall be member involvement throughout the planning and delivery of services. Services shall be:

1. Delivered in a culturally and linguistically competent manner in accordance with member's preferences and needs;

2. Respectful of the member receiving services;

3. Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and

4. Appropriate for age, development, and education.

Allowed Mode(s) of Delivery

Individual.

Provider Responsibilities

1. Report any changes in the member's condition or behavior that impact the member's health and safety to the appropriate MCO and if applicable, the community case manager;

2. Participate in team meetings as requested by the member's case manager;

3. Providers must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective

licensing authorities and in accordance with all applicable Louisiana Department of Health (LDH) policies;

4. Providers shall conduct self-audits, including conducting home visits, to ensure staff follow internal policies and procedures, and comply with service requirements established by LDH;

5. Utilize the LDH-designated electronic visit verification system (EVV) to "check in" and "check out" when direct service workers begin and end service delivery for a member in accordance with LDH-established EVV policies and procedures. The policies and procedures may be accessed at https://ldh.la.gov/page/3819;

   Providers shall have available computer equipment, software, and internet connectivity necessary to participate in required prior/post authorization, data collection, and electronic visit verification activities.

6. Providers shall not refuse to serve any member who chooses their agency, unless there is documentation to support an inability to meet the member's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services. LDH and the managed care entity must be notified immediately of the circumstances surrounding the refusal. The refusal request must be made in writing by the provider to LDH, or its designee, and to the member detailing why the provider is unable to serve the member. This requirement may only be waived by LDH or its designee;

7. Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area;

8. If the provider proposes involuntary transfer, discharge of a member, or if a provider closes in accordance with licensing standards, the following steps must be taken:

   a. The provider shall give written notice to the member, a family member and/or the authorized representative, if known, and the case manager, if applicable, at least 30 calendar days prior to the transfer or the discharge;

   b. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the member understands;

c. A copy of the written discharge/transfer notice shall be put in the member's record;

d. When the safety or health of members or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge to the member, a family member and/or the authorized representative, if known, and the case manager; and

e. The written notice shall include the following:

i. A reason for the transfer or discharge;

ii. The effective date of the transfer or discharge;

iii. An explanation of a member's right to personal and/or third parties' representation at all stages of the transfer or discharge process;

iv. Contact information for the Advocacy Center;

v. Names of provider personnel available to assist the member and family in decision making and transfer arrangements;

vi. The date, time and place for the discharge planning conference;

vii. A statement regarding the member's appeal rights;

viii. The name of the director, current address and telephone number of the Division of Administrative Law; and

ix. A statement regarding the member's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

9. Provider transfer or discharge responsibilities shall include:

   a. Holding a transfer or discharge planning conference with the member, family, case manager (if applicable), legal representative and advocate, if such is known;

   b. Developing discharge options that will provide reasonable assurance that the member will be transferred or discharge to a setting that can be expected to meet his/her needs;

   c. Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the member; and

   d. Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

Service Documentation

Providers must develop a service plan in collaboration with the member/member's family to include the specific activities to be performed, including frequency and anticipated/estimated duration of each activity, based on the member's goals, preferences, and assessed needs. The service plan must be developed prior to service delivery and updated at least every six (6) months, or more frequently based on changes to the member's needs or preferences. The PCS provider shall provide the plan to the member prior to service delivery and when the plan is updated.

Service Logs

Service logs document the PCS provided and billed. These service logs are the "paper trail" for services delivered by the direct service worker.

Direct service workers must complete a standardized service log at each visit to reflect services provided, and variations from the approved service plan and reason. The service log must also contain:

1. Name of the member;

2. Name of provider and direct service worker provider the service;

3. Assistance provided;

4. Date of service contact; and

5. Place of service.

Service logs must be:

1. Completed daily as tasks are performed (service logs may not be completed prior to the performance of a task); and

2. Signed and dated by the direct service worker and by the member or responsible representative after the work has been completed at the end of the week.

A separate log must be kept for each member. All portions of the service log must be completed each week.

In addition, direct services workers and providers must document services provided through the electronic visit verification system, in accordance with Section X.

Back-Up Staffing & Emergency Evacuation Plans

PCS providers must develop a back-up staffing plan in the event the assigned direct service worker is unable to provide support due to unplanned circumstances or emergencies that may arise during the direct service worker's shift. PCS providers must discuss available options for back-up coverage with the member or his/her authorized representative and complete the required staffing plan. The plan must include:

1. Person or persons responsible for back up coverage (including names, relationships, and contact phone numbers);

2. A toll-free telephone number with 24-hour availability that allows the recipient to contact the provider if the worker fails to show up for work; and

3. Provider and member signatures and dates.

In all instances when a direct service worker is unable to provide support, he/she must contact the provider and family/member immediately. Actions shall then be taken according to the member's back-up staffing plan. PCS providers must assess on an ongoing basis whether the back-up plan is

current and being followed according to the plan. The provider shall collaborate with the member, his/her authorized representative, case manager if applicable, and protective services if applicable to assure that any back-up staffing issues are resolved appropriately.

Providers must also ensure each member has a documented individualized emergency plan in preparation for, and response to, emergencies and disasters that may arise. This plan must identify specific resources available through the provider, natural resources, and the community. The provider must assess on an ongoing basis whether the emergency plan is current and being followed according to the plan. The emergency plan must be signed and dated by the member, authorized representative, and provider. If the emergency plan is activated, the provider bears responsibility for performance of those tasks agreed to in the plan.

The back-up staff plan and emergency plan must be provided to members and/or their authorized representative prior to delivering services and when the plan is updated.

Provider Qualifications

Agency

The PCS provider agency must:

1. Be licensed by LDH as a Home and Community Based Service provider/Personal Care Attendant agency per Revised Statute 40:2120.1 et seq. and LAC 48:I. Chapter 50;

2. Arrange for and maintains documentation that all persons, prior to employment, pass criminal background checks through the Louisiana Department of Public Safety, State Police. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the provider shall not hire and/or shall terminate the employment (or contract) of such individual. The provider shall not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

3. Arrange for and maintain documentation that all persons, prior to employment, are free from TB in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in recipients and staff. Results from testing

performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

4. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D);

5. Maintain documentation that all direct care staff, who are required to complete First Aid and CPR training, complete a training with a curriculum based on guidelines published by the American Heart Association (AHA) within 90 days of hire, which shall be renewed within a time period recommended by the AHA (See Appendix D);

6. Review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds including, but not limited to, licensed and unlicensed staff, interns and contractors:

   a. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General; and

   b. Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch.

7. Ensure and maintain documentation that all unlicensed persons employed by the organization complete a documented training in a recognized Crisis Intervention curriculum prior to handling or managing crisis responses, which shall be updated annually;

8. Maintain documentation of verification of completion of required trainings for all staff; and

9. Have a National Provider Identification (NPI) number, and include the agency NPI number and the NPI number of the individual rendering PCS on its behalf on all claims for Medicaid reimbursement, where applicable.

Staff

Direct care staff must meet the following individual qualifications:

1. Be at least 18 years of age;

2. Have a high school diploma, general equivalency diploma or trade school diploma in the area of human services (See Appendix B.), or demonstrate competency or verifiable work experience in providing support to persons with disabilities;

3. Pass criminal and professional background checks through the Louisiana Department of Public Safety, State Police prior to employment;

4. Pass a TB test prior to employment in accordance with the LAC 51:II.Chapter 5; OR be free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5;

5. Pass drug screen testing as required by agency's policies and procedures;

6. Complete a basic clinical competency training program approved by OBH prior to providing services. Psychiatrists and LMHPs are exempt from this training. (See Appendix D);

7. Complete First Aid and CPR training with a curriculum based on guidelines published by the American Heart Association (AHA). Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training (See Appendix D);

8. Pass a motor vehicle screen;

9. Not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

10. Not have a finding on the Louisiana State Adverse Action List;

11. Possess and provide documentation of a valid social security number;

12. Comply with law established by R.S. 40:2179 et seq. and R.S. 40:2120 et seq., and meet any additional qualifications established under Rules promulgated by LDH in association with these statutes; and

13. Have an NPI number which must be included on any claim submitted by that provider agency for reimbursement, where applicable.

Allowed Provider Types and Specialties

1. PT 24 Personal Care Attendant Agency:

   a. PS 5A (PCS-LTC) or 5D (PCS-LTC/EPSDT); and

   b. Provider Subspecialty 8E CSoC/Behavioral Health.

2. PT 24 Personal Care Attendant Agency, PS 8E CSoC/Behavioral Health.

Limitations/Exclusions

1. PCS does not include administration of medication; insertion and sterile irrigation of catheters; irrigation of any body cavities which require sterile procedures; complex wound care; or skilled nursing services as defined in the State Nurse Practice Act.

2. Services must be provided in home and community-based settings, and may not be provided in the following settings:

   a. In a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of personal care services;

b. In the direct service worker's home; and

c. In a nursing facility, Intermediate Care Facility for the Developmentally Disabled, Institute for Mental Disease, or other licensed congregate setting.

3. There shall be no duplication of services including the following:

a. PCS may not be provided while the member is attending or admitted to a program or setting that provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided;

b. IADLs may not be performed in the member's home when the member is absent from the home. Exceptions may be approved by the Medicaid managed care medical director on a case-by-case, time-limited basis; and

c. PCS may not be billed during the time the member has been admitted to a hospital, nursing home, or residential facility. Services may be provided and billed on the day the member is admitted to the hospital and following the member's discharge.

4. PCS shall not supplant care provided by natural supports;

5. PCS does not include room and board, maintenance, upkeep, and/or improvement of the member's or family's residence;

6. PCS may not be provided outside the state of Louisiana unless a temporary exception has been approved by the Medicaid managed care entity;

7. Direct service workers may not work more than 16 hours in a 24-hour period; and

8. The following individuals are prohibited from being reimbursed for providing services to a member:

a. Biological, legal or step first, second, third or fourth degree relatives;

b. First-degree relatives include parents, spouses, siblings, and children;

c. Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces;

d. Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins;

e. Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins; and

f. Curator, tutor, legal guardian, authorized representative, and any individual who has power of attorney.

Billing

1. The service unit is 15 minutes and is reimbursed at a flat rate, with the exception of the per diem rate for which the unit is a per day rate;

2. Reimbursement for services may be withheld or denied if the provider fails to use the EVV system or does not use the system in compliance with LDH's policies and procedures for EVV; and

3. Transportation is not a required component of PCS although providers may choose to furnish transportation for members during the course of providing PCS. If transportation is furnished, the provider must accept all liability for their employee/direct service worker transporting a member. It is the responsibility of the provider to ensure the employee/direct service worker has a current, valid driver's license, automobile liability insurance, and pass a motor vehicle screen prior to transporting members.