# Title 50
# PUBLIC HEALTH—MEDICAL ASSISTANCE
# Part XXXIII. Behavioral Health Services

## Subpart 1. Statewide Management Organization

## Chapter 1. General Provisions

### §101. Introduction

A. The Medicaid Program hereby adopts provisions to establish a comprehensive system of delivery for behavioral health services as part of the Louisiana Behavioral Health Partnership initiative. These services shall be administered under the authority of the Department of Health and Hospitals, Office of Behavioral Health, in collaboration with a Statewide Management Organization (SMO) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The provisions of this Rule shall apply only to the behavioral health services provided to Medicaid recipients/enrollees by or through the SMO.

C. A statewide management organization shall operate as a prepaid inpatient healthcare plan (PIHP/SMO) procured through a competitive request for proposal (RFP) process. The PIHP/SMO shall assist with the state's system reform goals to support individuals with behavioral health needs in families, homes, communities, schools, and jobs.

D. Through the utilization of a SMO, it is the department's goal to:

1. increase access to a broad array of evidence-based home and community-based services that promote hope, recovery and resilience;

2. improve quality by establishing and measuring outcomes;

3. manage costs through effective utilization of State, federal, and local resources; and

4. foster reliance on natural supports that sustain individuals and families in homes and communities.

E. The PIHP/SMO shall be paid on a non-risk basis for children's services, for individuals with retroactive eligibility, and for individuals in the Spend-Down Medically Needy Program. The PIHP/SMO shall be paid on a risk basis for adult 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, Bureau of Health Services Financing, LR 38:360 (February 2012).

### §103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in the coordinated behavioral health system of care:

1. Section 1931 Children and Related Populations. These are children eligible under §1931 of the Social Security Act, poverty-level related groups and optional groups of older children;

2. Section 1931 Adults and Related Populations. These are adults eligible under §1931 of the Social Security Act, poverty-level pregnant women and optional groups of caretaker relatives;

3. adults who are blind or have a disability and related populations, age 18 and over;

4. children who are blind or have a disability and related populations, under age 18;

5. aged and related populations, age 65 and older who are not blind, do not have a disability, and are not members of the §1931 Adult Population;

6. children who receive foster care or adoption assistance (Title IV-E), or who are in foster care or who are otherwise in an out-of-home placement; and

7. Title XXI SCHIP (LaCHIP, LaCHIP Phase 2 and LaCHIP Phase 3) populations.

B. Mandatory participants shall be automatically enrolled and disenrollment from the PHIP/SMO is not permitted.

C. Notwithstanding the provisions of Subsection A of this Section, the following Medicaid recipients are excluded from enrollment in the PIHP/SMO:

1. recipients who receive both Medicare and Medicaid benefits;

2. recipients enrolled in the Medicare Beneficiary Programs (QMB, SLMB, QDWI and QI-1);

3. adults who reside in an intermediate care facility for persons with developmental disabilities (ICF/DD);

4. recipients of Refugee Cash Assistance;

5. recipients enrolled in the Regular Medically Needy Program;

6. recipients enrolled in the Tuberculosis Infected Individual Program;

7. recipients who receive emergency services only coverage;

8. recipients eligible through the LaCHIP Affordable Care Plan Program (Phase 5);

9. recipients who receive services through the Program of All-Inclusive Care for the Elderly (PACE);

10. recipients enrolled in the Low Income Subsidy Program;

11. participants in the TAKE CHARGE Family Planning Waiver; and

12. recipients enrolled in the LaMOMS Program.

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, Bureau of Health Services Financing, LR 38:361 (February 2012).

**§105. Enrollment Process**

A. The PIHP/SMO shall abide by all enrollment and disenrollment policies and procedures as outlined in the contract entered into by department and the SMO.

B. The PIHP/SMO shall ensure that mechanisms are implemented to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing conditions that require a course of treatment or regular care monitoring. The assessment mechanism shall incorporate appropriate health care professionals.

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, Bureau of Health Services Financing, LR 38:361(February 2012).

**§107. Enrollee Rights and Responsibilities**

A. The PIHP/SMO enrollee's rights shall include, but are not limited to the right to:

1. participate in treatment decisions, including the right to:

a. refuse treatment;

b. seek second opinions; and

d. receive assistance with care coordination from the primary care providers (PCP's) office;

2. express a concern about their provider or the care rendered via a grievance process;

3. appeal a PIHP/SMO decision through the PIHP/SMO's internal process and/or the state fair hearing process;

4. receive a response about a grievance or appeal decision within a reasonable period of time;

5. receive a copy of his/her medical records;

6. be furnished health care services in accordance with federal regulations, including those governing access standards;

7. choose a participating network health care professional in accordance with federal and state regulations; and

8. be allowed to receive a specialized service outside of the network if a qualified provider is not available through the network.

B. The Medicaid recipient/enrollee's responsibilities shall include, but are not limited to:

1. informing the PIHP/SMO of the loss or theft of their Medicaid identification card;

2. presenting their identification card when accessing behavioral health services;

3. being familiar with the PIHP/SMO procedures to the best of his/her abilities;

4. contacting the PIHP/SMO, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified;

5. providing participating network providers, or any other authorized provider, with accurate and complete medical information;

6. following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

7. making every effort to keep any agreed upon appointments and follow-up appointments and contacting the provider in advance if unable to do so; and

8. accessing services only from specified providers contracted with the PIHP/SMO.

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, Bureau of Health Services Financing, LR 38:361 (February 2012).

# Chapter 3. Statewide Management Organization Participation

**§301. Participation Requirements and Responsibilities**

A. In order to participate in the Medicaid Program, a statewide management organization shall execute a contract with the department, and shall comply with all of the terms and conditions set forth in the contract.

B. A PIHP/SMO shall:

1. manage behavioral health services for adults with substance abuse disorders as well as adults with functional behavioral health needs;

2. manage mental health and substance abuse care for all eligible children and youth in need of behavioral health care on a non-risk basis;

3. on a non-risk basis, implement a coordinated system of care for a subset of children and youth who are in, or at risk of, out-of-home placement;

a. This system will be phased in over the term of the contract;

4. establish credentialing and re-credentialing policies consistent with federal and state regulations;

5. ensure that provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

6. maintain a written contract with subcontractors that specifies the activities and reporting responsibilities delegated to the subcontractor and such contract shall also provide for the PIHP/SMO's right to revoke said delegation, terminate the contract, or impose other sanctions if the subcontractor's performance is inadequate;

7. contract only with providers of behavioral health services who are licensed and/or certified and meet the state of Louisiana credentialing criteria;

8. ensure that contracted rehabilitation providers are employed by a rehabilitation agency, school or clinic licensed and/or certified, and authorized under state law to provide these services;

9. sub-contract with a sufficient number of providers to render necessary services to Medicaid recipients/enrollees;

10. require each provider to implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify special conditions of the enrollee that require a course of treatment or regular care monitoring;

11. ensure that treatment plans meet the following requirements:

a. are developed by the enrollee's primary care provider (PCP) with the enrollee's participation and in consultation with any specialists' providing care to the enrollee with the exception of treatment plans developed for recipients in the Home and Community Based Services (HCBS) Waiver. The wraparound agency shall develop treatment plans for recipients who receive behavioral health services through the HCBS Waiver;

b. are approved by the PIHP/SMO in a timely manner, if required;

c. are in accordance with any applicable state quality assurance and utilization review standards; and

d. allow for direct access to any specialist for the enrollee's condition and identified needs, in accordance with the contract; and

12. ensure that Medicaid recipients/enrollees receive information:

a. in accordance with federal regulations and as described in the contract and departmental guidelines;

b. on available treatment options and alternatives in a manner appropriate to the enrollee's condition and ability to understand;

c. about available experimental treatments and clinical trials along with information on how such research can be accessed even though the Medicaid Program will not pay for the experimental treatment.

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, Bureau of Health Services Financing, LR 38:362 (February 2012).

**§303. Benefits and Services**

A. The PIHP/SMO shall ensure that behavioral health benefits and services be furnished to Medicaid recipients/enrollees in an amount, duration and scope that are at least equivalent to those furnished to enrollees under the Louisiana Medicaid State Plan. The benefits and services shall be provided to Medicaid recipients/enrollees as provided under the terms of the contract and department-issued guidelines.

B. The PIHP/SMO:

1. shall ensure that medically necessary behavioral health services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished;

2. may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;

3. may place appropriate limits on a service:

a. on the basis of medical necessity; and

b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

4. shall provide benefits and services as outlined and defined in the contract and shall provide medically necessary and appropriate care to Medicaid PIHP/SMO enrollees; and

C. The benefits and services provided to enrollees shall include, but are not limited to, those services specified in the contract between the PIHP/SMO and the department.

1. Policy transmittals, State Plan amendments, Rules and regulations, provider bulletins, provider manuals and fee schedules issued by the department are the final authority regarding 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, Bureau of Health Services Financing, LR 38:362 (February 2012).

**§305. Service Delivery**

A. The PIHP/SMO shall ensure that behavioral health services rendered to enrollees are medically necessary, are authorized or coordinated by the PIHP/SMO, and are provided by mental health professionals according to their scope of practice and licensing in the state of Louisiana.

B. Access to emergency services and family-oriented services shall be assured within the network.

C. The PIHP/SMO shall be required to contract with at least one federally qualified health center (FQHC) in each medical practice region of the state (according to the practice patterns within the state) if there is an FQHC which can provide substance abuse or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications.

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, Bureau of Health Services Financing, LR 38:363 (February 2012).

# Chapter 5. Reimbursement

**§501. Reimbursement Methodology**

A. The department, or its fiscal intermediary, shall make actuarially sound monthly capitation payments to the PIHP/SMO on the basis of prepaid capitation payments or other payment arrangements that do not use fee-for-service payment rates.

B. The PIHP/SMO is paid on a risk basis for adult behavioral health services and is paid on a non-risk basis for all children's behavioral health services and any services to individuals with retroactive eligibility in the month the enrollee meets medically needy spend-down requirements.

C. Effective for dates of service on or after July 1, 2012, the monthly capitation payments to the PIHP/SMO for adult behavioral health services shall be reduced by 1.927 percent of the monthly capitation payments on file as of June 30, 2012.

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, Bureau of Health Services Financing, LR 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013).

# Chapter 7. Grievance and Appeals Process

**§701. General Provisions**

A. The PIHP/SMO shall be required to have an internal grievance system and internal appeal process which allows a Medicaid recipient/enrollee to challenge a decision made, a denial of coverage, or a denial of payment for services.

B. An enrollee, or a provider on behalf of an enrollee, must file an appeal within 30 calendar days from the date on the notice of action.

C. An enrollee must file a grievance within 180 calendar days of the occurrence or incident which is the basis for the grievance.

D. An enrollee must exhaust the PIHP/SMO grievance and appeal process before requesting a state fair hearing.

E. The PIHP/SMO shall provide Medicaid enrollees with information about the state fair hearing process within the timeframes established by the department and in accordance with the state fair hearing policies.

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, Bureau of Health Services Financing, LR 38:363 (February 2012).

# Chapter 9. Monitoring Activities

**§901. General Provisions**

A. The contracted PIHP/SMO shall be accredited by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) or agrees to submit application for accreditation at the earliest possible date as allowed by NCQA or URAC. Once accreditation is achieved, it shall be maintained through the life of this agreement.

B. The PIHP/SMO shall be required to track grievances and appeals. Grievance and appeal data shall be included in quarterly QI reporting and are reviewed at least annually by the department or its designee.

C. The PIHP/SMO shall report demographic data, outcomes measures, utilization and special needs population (target population) data to the department through the required OBH database.

D. The PIHP/SMO shall submit documentation to the department to substantiate that it offers an appropriate range of services that is adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.

E. The PIHP/SMO shall conduct Performance Improvement Projects (PIPs) that are designed to achieve, through on-going measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

F. The PIHP/SMO shall annually report the number and types of Title XIX practitioners (by service type not facility or license type) relative to the number and types of Medicaid providers at the start date of the contract.

G. The PIHP/SMO shall be required to conduct statistically valid sample reviews.

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, Bureau of Health Services Financing, LR 38:363 (February 2012).