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 38:366 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:324 (February 2017).

§8103. Recipient Qualifications

A. The target population for the Home and Community-Based Behavioral Health Services Waiver program shall be Medicaid recipients who:

1. are from the age of 5 years old through the age of 20 years old effective March 1, 2017:

a. recipients enrolled in the program prior to this date, who are between the ages of 0 through 4 or 20 through 21, may continue to be served through this waiver as long as they continue to meet the level of care criteria; and

b. prospectively recipients must be at least age 5 through age 20 to receive waiver services;

2. have a qualifying mental health diagnosis;

3. are identified as seriously emotionally disturbed (SED), which applies to youth under the age of 18 or seriously mentally ill (SMI) which applies to youth ages 18-21;

4. require hospital or nursing facility level of care, as determined by the department’s designated assessment tools and criteria;

5. meet financial eligibility criteria; and

6. reside in a home and community-based setting as defined in 42 CFR 441.301(c)(4) and in accordance with the department's policy and procedures.

B. The need for waiver services is re-evaluated at a minimum of every 180 days, and at any time the family feels that it is appropriate, as needs change, and/or as goals are completed. The re-evaluation determines if the recipient continues to be in need of psychiatric hospitalization or nursing facility level of care.

Chapter 85. Provider Participation

§8501. Provider Responsibilities

A. Each provider of home and community-based behavioral health waiver services shall enter into a contract with the CSoC contractor in order to receive reimbursement for Medicaid covered services.

B. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department.

C. Providers of waiver services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery.

D. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. Providers shall maintain case records that include, at a minimum:

1. a copy of the plan of care;
2. the name of the individual;
3. the dates of service;
4. the nature, content and units of services provided;
5. the progress made toward functional improvement; and
6. the goals of the plan of care.

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 38:368 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2362 (November 2015).

Chapter 87. Reimbursement

§8701. Reimbursement Methodology

A. Reimbursement for home and community-based behavioral health waiver services shall be based upon the established Medicaid fee schedule for the services rendered.

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 38:368 (February 2012).