

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

11-10

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

~~January 1, 2012~~ 1 March, 2012

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 440.60, 440.130, 440.40(b), 441 Subpart B
42 CFR 447 Subpart B**

7. FEDERAL BUDGET IMPACT:

a. FFY 2012 \$24,617.07
b. FFY 2013 \$33,204.42

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Item 4b, Page 8a
Attachment 3.1-A, Item 4b, Page 9
Attachment 3.1-A, Item 4b, Pages 9a, 9b, 9c, 9d, 9e, 9f, 9g
Attachment 3.1-A, Item 9, Page 1
Attachment 3.1-A, Item 13d, Page 5
Attachment 3.1-A, Item 13d, Page 6
Attachment 4.19-B, Item 4b, Page 3
Attachment 4.19-B, Item 4b, Page 3a
Attachment 4.19-B, Item 13d, Page 2
Attachment 4.19-B, Item 13d, Page 3

See Pen & Ink Change
below.

Remove:

Attachment 3.1-A, Item 13d, Pages 7-8
Attachment 3.1-A, Item 13d, Pages 9,10,11,11a,12,13,14,15
Attachment 3.1-A, Item 13d, Pages 16, 17
Attachment 4.19-B, Item 13d, Page 3a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR
ATTACHMENT (If Applicable):

Same (TN 06-34)
Same (TN 00-13)
None (New Pages)
Same (TN 00-13)
Same (TN 05-34)
Same (TN 09-33)
Same (TN 06-34)
None (New Page)
Same (TN 09-33)
Same (TN 10-55)

See Pen & Ink Change
below.

TN 05-34
TN 10-19
TN 08-07
Pending TN 10-70

10. SUBJECT OF AMENDMENT: **This amendment is part of the CSoC behavioral health service package. This amendment establishes the mental health for children and youth including expansion of services offered by licensed mental health professionals and rehabilitative services; changes substance abuse rehabilitative services for children and adults; and replaces existing provisions.**

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:

13. TYPED NAME:

Bruce D. Greenstein

14. TITLE:

Secretary

15. DATE SUBMITTED:

March 10, 2011

16. RETURN TO:

**Don Gregory, Medicaid Director
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: 10 March, 2011

18. DATE APPROVED: 8 February, 2012

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

1 January, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:

Dorothy Ingram for Bill Brooks

21. TYPED NAME:

Bill Brooks

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

* Pen and Ink change made per State's e-mail dated 10 January, 2012 changing pages submitted for approval and their superseded information.

* Pen & Ink change per State's Letter dated 7/15/11 changing the effective date from
1 January, 2012 to 1 March, 2012

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202



Division of Medicaid & Children's Health, Region VI

February 8, 2012

Our Reference: SPA LA 11-10

Mr. Don Gregory, State Medicaid Director
Department of Health and Hospitals
Bienville Building
628 North 4th Street
Post Office Box 91030
Baton Rouge, LA 70821-9030

Attn: Keydra Singleton

Dear Mr. Gregory:

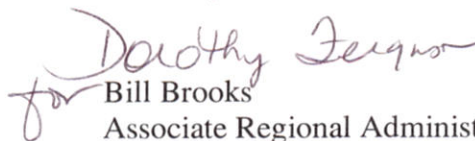
We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 11-10. This state plan amendment establishes program criteria and reimbursement for mental health rehabilitation services for children and youth. It expands services and changes substance abuse rehabilitation services. This SPA is part of the Louisiana Behavioral Health Partnership Program.

In the future, when the State submits a State Plan Amendment (SPA) that may impact Indians or Indian health providers, CMS will look for evidence of the State's tribal consultation process for the SPA. Pursuant to section 1902(a) (73) of the Act added by section 5006(e) of the Recovery and Reinvestment Act of 2009, the State must evidence to CMS regarding the solicitation of advice prior to submission of the SPA. This consultation must include all federally recognized tribes, Indian Health Service and Urban Indian Organizations within the state.

Transmittal Number 11-10 is approved with an effective date of March 1, 2012 as requested. A copy of the HCFA-179, Transmittal No. 11-10 dated March 10, 2011 is enclosed along with the approved plan pages.

If you have any questions, please contact Ford Blunt III at ford.blunt@cms.hhs.gov or by phone at (214) 767-6381.

Sincerely,


for Bill Brooks
Associate Regional Administrator

Enclosures

<p><u>State Plan Page</u></p> <p>Attachment 3.1-A, Item 4b, Page 8a Attachment 3.1-A, Item 4b, Page 9 Attachment 3.1-A, Item 4b, Page 9a Attachment 3.1-A, Item 4b, Page 9b Attachment 3.1-A, Item 4b, Page 9c Attachment 3.1-A, Item 4b, Page 9d Attachment 3.1-A, Item 4b, Page 9e Attachment 3.1-A, Item 4b, Page 9f Attachment 3.1-A, Item 4b, Page 9g</p> <p>Attachment 3.1-A, Item 13d, Page 5 Attachment 3.1-A, Item 13d, Page 6</p> <p>Attachment 3.1-A, Item 9, Page 1</p> <p>Attachment 4.19-B, Item 4b, Page 3 Attachment 4.19-B, Item 4b, Page 3a Attachment 4.19-B, Item 4b, Page 3b Attachment 4.19-B, Item 4b, Page 3c Attachment 4.19-B, Item 4b, Page 3d</p> <p>Attachment 4.19-B, Item 13d, Page 5</p> <p><u>Remove</u></p> <p>Attachment 3.1-A, Item 13d, Page 7 Attachment 3.1-A, Item 13d, Page 8 Attachment 3.1-A, Item 13d, Page 9 Attachment 3.1-A, Item 13d, Page 10 Attachment 3.1-A, Item 13d, Page 11 Attachment 3.1-A, Item 13d, Page 11a Attachment 3.1-A, Item 13d, Page 12 Attachment 3.1-A, Item 13d, Page 13 Attachment 3.1-A, Item 13d, Page 14 Attachment 3.1-A, Item 13d, Page 15 Attachment 3.1-A, Item 13d, Page 16 Attachment 3.1-A, Item 13d, Page 17</p>	<p><u>Supersedes</u></p> <p>Same (TN 06-34) Same (TN 00-13) None (New Page) None (New Page) None (New Page) None (New Page) None (New Page) None (New Page) None (New Page)</p> <p>Same (TN 10-70) Same (TN 05-34)</p> <p>Same (TN 00-13)</p> <p>Same (TN 06-34) None (New Page) None (New Page) None (New Page) None (New Page)</p> <p>None (TN 05-34)</p> <p><u>Supersedes</u></p> <p>Same (TN 05-34) Same (TN 05-34) Same (TN 10-70) Same (TN 10-55) Same (TN 10-70) Same (TN 10-55) Same (TN 10-19) Same (TN 10-19) Same (TN 10-19) Same (TN 10-19) Same (TN 08-07) Same (TN 08-07)</p>
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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Licensed Mental Health Practitioner (LMHP):
42 CFR 440.60 - Other Licensed Practitioners

A licensed mental health practitioner (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

STATE	<u>Louisiana</u>
DATE REAPP	<u>3-10-11</u>
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Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. In addition, they may not be debarred, suspended, or otherwise excluded from participating in procurement activities under the State and Federal laws, regulations, and policies including the Federal Acquisition Regulation, Executive Order No. 12549, and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the Federal Acquisition Regulation, of a person excluded, debarred, suspended or otherwise excluded under State and Federal laws, regulations, and policies may not participate.

All services must be authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery. In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by Department of Health and Hospitals, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice under state law. LPCs are limited by scope of practice under state law to diagnosing conditions or disorders requiring mental health counseling and may not use appraisal instruments, devices or procedures for the purpose of treatment planning, diagnosis, classification or description of mental and emotional disorders and disabilities, or of disorders of personality or behavior, which are outside the scope of personal problems, social concerns, educational progress and occupations and careers. Per the State's practice act and consistent with State Medicaid Regulation, Medical and Licensed Psychologists may supervise up to two unlicensed assistants or post-doctoral individuals in supervision for licensure.

Inpatient hospital visits are limited to those ordered by the individual's physician. Visits to nursing facility are allowed for psychologists if a PASRR (Preadmission Screening and Resident Review indicates it is medically necessary treatment. Social worker visits are included in the Nursing Visit and may not be billed separately. Visits to ICF-MR facilities are non-covered. All LMHP services provided while a person is a resident of an IMD such as a free standing psychiatric hospital or psychiatric residential treatment facility are content of the institutional service and not otherwise reimbursable by Medicaid. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by Department of Health and Hospitals. A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

TN# 11-10

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Effective Date March 1, 2012

Supersedes
TN# 06-34

SUPERSEDES: TN- 06-34

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Rehabilitation Services:
42 CFR 440.130(d)

The following explanations apply to all rehabilitation services, which are the following:

- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation
- Crisis Intervention
- Therapeutic Group Home

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible children with significant functional impairments resulting from an identified mental health or substance abuse diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed mental health practitioner or physician who is acting within the scope of his/her professional licensed and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a individual to his/her best age-appropriate functional level.

Service Utilization:

Services are subject to prior approval, must be medically necessary and must be recommended by a licensed mental health practitioner or physician according to an individualized treatment plan. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services.

Anyone providing addiction or mental health services must be certified by Department of Health and Hospitals, in addition to any required scope of practice license required for the facility or agency to practice in the State of Louisiana. Providers must maintain medical records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan.

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Supersedes
TN# 00-13

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SUPERSEDES: TN- 00-13

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Rehabilitation Services:
42 CFR 440.130(d)

Medical necessity of the services is determined by a licensed mental health practitioner or physician conducting an assessment consistent with state law, regulation and policy. Services provided at a work site must not be job tasks oriented and must be directly related to treatment of an individual behavioral health needs. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institution for mental disease (IMD). Room and board is excluded from any rates provided in a residential setting. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by Department of Health and Hospitals.

Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the Plan of Care. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

Definitions:

The services are defined as follows:

- I. Community Psychiatric Support and Treatment (CPST) are goal directed supports and solution-focused interventions intended to achieve identified goal or objectives as set forth in the individual's individualized treatment plan. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. CPST contacts may occur in community or residential locations where the person lives, works, attends school, and/or socializes.

This service may include the following components:

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.

SUPERSEDES: NONE - NEW PAGE

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Rehabilitation Services:

42 CFR 440.130(d)

- C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.
- E. Restoration, rehabilitation and support to develop skills to locate, rent and keep a home, landlord/tenant negotiations; selecting a roommate and renter's rights and responsibilities.
- F. Assisting the individual to develop daily living skills specific to managing their own home including managing their money, medications, and using community resources and other self care requirements.

Provider qualifications: Must have a MA/MS degree in social work, counseling, psychology or a related human services field to provide all aspects of CPST including counseling. Other aspects of CPST except for counseling may otherwise be performed by an individual with BA/BS degree in social work, counseling, psychology or a related human services field or four years of equivalent education and/or experience working in the human services field. Certification in the State of Louisiana to provide the service, which includes criminal, professional background checks, and completion of a state approved standardized basic training program.

Service Utilization: Caseload Size must be based on the needs of the clients/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP as defined in 3.1A item 4.b, Page 8a with experience regarding this specialized mental health service. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist.

- 2. Psychosocial Rehabilitation (PSR) services are designed to assist the individual compensate for or eliminate functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of psychosocial rehabilitation is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. PSR contacts may occur in community or residential locations where the person lives, works, attends school, and/or socializes. PSR components include:
 - A. Restoration, rehabilitation and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and promote effective functioning in the individual's social environment including home, work and school.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Rehabilitation Services:
42 CFR 440.130(d)

- B. Restoration, rehabilitation and support with the development of daily living skills to improve self management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.
- C. Assisting with the implementation of daily living skills so the person can remain in a natural community location
- D. Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider Qualifications: Must be at least 18 years old, and have a high school diploma or equivalent. Additionally, the provider must be at least three years older than an individual under the age of 18. Certification in the State of Louisiana to provide the service, which includes criminal, professional background checks, and completion of a state approved standardized basic training program.

Service Utilization: Initial authorization of 750 hours of group psychosocial rehabilitation per calendar year. This authorization can be exceeded when medically necessary through prior authorization. The PSR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP as defined in 3.1A item 4.b, Page 8a with experience regarding this specialized mental health service.

- 3. Crisis Intervention (CI) services are provided to a person who is experiencing a psychiatric crisis, designed to interrupt and/or ameliorate a crisis experience including an preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of Crisis Interventions are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. Crisis Intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school, and/or socializes.
 - A. A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.
 - B. Short-term crisis interventions including crisis resolution and de-briefing with the identified Medicaid eligible individual.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Rehabilitation Services:

42 CFR 440.130(d)

- C. Follow-up with the individual, and as necessary, with the individuals' caretaker and/or family members.
- D. Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis

Provider Qualifications: Must be at least 20 years old and have an AA/AS degree in social work, counseling, psychology or a related human services field or two years of equivalent education and/or experience working in the human services field. Additionally, the provider must be at least three years older than an individual under the age of 18. Certification in the State of Louisiana to provide the service, which includes criminal, professional background checks, and completion of a state approved standardized basic training program. The assessment of risk, mental status, and medical stability must be completed by a LMHP or PIHP-designated LMHP as defined in 3.1A item 4.b, Page 8a with experience regarding this specialized mental health service, practicing within the scope of their professional license. This assessment is billed separately by the LMHP under EPSDT Other Licensed Practitioner per 3.1A item 4.b, Page 8a.

Service Utilization: All individuals who self identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care. The crisis plan developed by the unlicensed professional from the assessment and all services delivered during a crisis must be provided under the supervision of a LMHP or PIHP-designated LMHP as defined in 3.1A item 4.b, Page 8a with experience regarding this specialized mental health service, and such must be available at all times to provide back up, support, and/or consultation. Crisis services cannot be denied based upon substance use.

The Crisis Intervention provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service. Crisis Intervention – Emergent is authorized up to 6 hours per episode. Crisis Intervention – Ongoing is authorized up to 66 hours per episode. An episode is defined as the initial face to face contact with the individual until the current crisis is resolved, not to exceed 14 days. The individual's chart must reflect resolution of the crisis which marks the end of the current episode. If the individual has another crisis within 7 calendar days of a previous episode, it shall be considered part of the previous episode and a new episode will not be allowed. Initial authorization can be exceeded when medically necessary through prior authorization.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Rehabilitation Services:
42 CFR 440.130(d)

4. Therapeutic Group Homes (TGHs) provide a community-based rehabilitative residential supports in a home-like setting of no greater than eight beds under the supervision and program oversight of a psychiatrist or psychologist. The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in his/her home and community, and to regularly attend and participate in work, school or training. TGHs deliver rehabilitative supports through an array of clinical and related activities within the home including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. TGH treatment must target reducing the severity of the behavioral health issue that was identified as the reason for admission which primarily focus on children in transition or in crisis where the expected length of stay is less than one month. Most often, targeted behaviors will relate directly to the child or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts). Treatment must:
- Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation
 - Decrease problem behavior and increase developmentally-appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement
 - Transition child or adolescent from therapeutic group home to home or community based living with outpatient treatment (e.g., individual and family therapy).

The State Medicaid agency or its designee must have determined that less intensive levels of rehabilitative treatment are unsafe, unsuccessful or unavailable. The child must require active treatment that would not be able to be provided at a less restrictive level of care is being provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff. The setting must be ideally situated to allow ongoing participation of the child's family. The child or adolescent must attend a school in the community (e.g., a school integrated with children not from the group home and not on the grounds of the group home). In this setting, the child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.

TGHs provide twenty-four hours/day, seven days/week structured and supportive living environment. However, Medicaid does not reimburse for supervision or room and board. Integration with community resources is provided to plan and arrange access to a range of educational and therapeutic services. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability, when appropriate and relevant. Screening and assessment is required upon admission and every 14 days thereafter to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues. The individualized, strengths-based services and supports:

- Are identified in partnership with the child or adolescent and the family and support system, to the extent possible, and if developmentally appropriate
- Are based on both clinical and functional assessments
- Are clinically monitored and coordinated, with 24-hour availability
- Are implemented with oversight from a licensed mental health professional
- Assist with the development of skills for daily living and support success in community settings, including home and school

The TGH is required to coordinate with the child or adolescent's community resources, with the goal of transitioning the youth out of the program as soon as possible and appropriate. Discharge planning begins upon admission with concrete plans for the child to transition back into the community beginning within the first week of admission with clear action steps and target dates outlined in the treatment plan. The treatment plan must include behaviorally-measurable discharge goals.

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STATE	<u>Louisiana</u>
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NOFA 179	<u>11-10</u>

A

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Rehabilitation Services:
42 CFR 440.130(d)

For treatment planning, the program must use a standardized assessment and treatment planning tool such as the Child and Adolescent Needs and Strengths. The assessment protocol must differentiate across life domains, as well as risk and protective factors, sufficiently so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment. The tool should also allow tracking of progress over time. The specific tools and approaches used by each program must be specified in the program description and are subject to approval by the State. In addition, the program must ensure that requirements for pretreatment assessment are met prior to treatment commencing. Annually, facilities must submit documentation demonstrating compliance with fidelity monitoring for at least two evidence-based practices (EBP) and/or one level of ASAM criteria. The State must approve the auditing body providing the EBP/ASAM fidelity monitoring. TGH facilities may specialize and provide care for sexually deviant behaviors, substance abuse, or dually diagnosed individuals. If a program provides care to any of these categories of youth, the program must submit documentation regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the ASAM level of care being provided.

For service delivery, the program must incorporate at least two research-based approaches pertinent to the sub-populations of TGH clients to be served by the specific program. The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in TGH settings must be approved by the State. For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not.

Provider Qualifications: A Therapeutic Group Home must be accredited and licensed as residential treatment facility by the Louisiana Department of Health and Hospitals and may not exceed eight beds. TGH staff must be supervised by a psychiatrist or psychologist with experience in evidence-based treatments.

Direct care staff must be at least 18 years old, and have a high school diploma or equivalent. Additionally, the direct care staff must be at least three years older than an individual under the age of 18. Certification in the State of Louisiana to provide the service, which includes criminal, professional background checks, and completion of a state approved standardized basic training program. At least 21 hours of active treatment per week for each child is required to be provided by qualified staff (e.g., having a certification in the EBPs selected by the facility and/or licensed practitioners operating under their scope of practice in Louisiana), consistent with each child's treatment plan and meeting assessed needs. Any care provided by licensed practitioners is billed separately under the Other Licensed Practitioner section of the State Plan (Item 4.b, page 8b).

Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their child.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

Rehabilitation Services:

42 CFR 440.130(d)

Unit of Service: Reimbursement for the TGH is based on a daily rate for the services provided by unlicensed practitioners.

Service Utilization: Licensed psychologists and LMHPs as defined in 3.1A item 4.b, Page 8a bill for their services separately under the approved State Plan for EPSDT Other Licensed Practitioners, item 4b, page 8a. The psychiatrist or psychologist must provide twenty-four (24) hour, on-call coverage seven (7) days a week. The psychologist or psychiatrist must see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care every 14 days. Although the psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner must assume professional responsibility for the services provided and assure that the services are medically appropriate. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention (by a psychiatrist) are required of TGH, but provided and billed separately by licensed practitioners for direct time spent.

TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. The facility is expected to provide recreational activities for all enrolled children but not use Medicaid funding for payment of such non-Medicaid activities. Medicaid does not reimburse for room and board.

TGHs may not be Institutions for Mental Disease. Each organization owning Therapeutic Group Homes must ensure in no instance does the operation of multiple TGH facilities constitute operation of an Institution of Mental Disease. All new construction, newly acquired property or facility or new provider organization must comply with facility bed limitations not to exceed eight beds. Existing facilities may not add beds if the bed total would exceed eight beds in the facility.

Average length of stay ranges from 14 days to 120 days. Discharge will be based on the child no longer making adequate improvement in this facility (and another facility is being recommended) or the child no longer having medical necessity at this level of care. Continued TGH stay should be based on a clinical expectation that continued treatment in the TGH can reasonably be expected to achieve treatment goals and improve or stabilize the child or adolescent's behavior, such that this level of care will no longer be needed and the child or adolescent can return to the community. Transition should occur to a more appropriate level of care (either more or less restrictive) if the child or adolescent is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care (e.g., child or adolescent's behavior and/or safety needs requires a more restrictive level of care, or alternatively, child or adolescent's behavior is linked to family functioning and can be better addressed through a family/home-based treatment).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

Attachment 3.1 -A
Item 13.d., Page 7 - 17

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED BELOW:

CITATION Medical and Remedial 11. Mental Health Rehabilitation Services
42 CFR Care and Services
440.130 Item 13.d. (cont'd)

(Withdrawn)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

Attachment 3.1 -A
Item 13.d., Page 5

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED BELOW:

CITATION Medical and Remedial 11. Mental Health Rehabilitation Services
42 CFR Care and Services
440.130 Item 13.d. (cont'd)

Rehabilitation Services:
42 CFR 440.130(d)

4. Addiction services include an array of individual centered outpatient, intensive outpatient, and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. These services are designed to help individuals achieve changes in their substance abuse behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to undermine the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment, or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services. Outpatient, intensive outpatient, and residential services are delivered on an individual or group basis in a wide variety of settings including treatment in residential settings of 16 beds or less designed to help individuals achieve changes in their substance abuse behaviors.

Limitations:

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible individuals with significant functional impairments resulting from an identified addiction diagnosis. Services are subject to prior approval, must be medically necessary and must be recommended by a licensed mental health practitioner or physician, who is acting within the scope of his/her professional licensed and applicable state law, to promote the maximum reduction of symptoms and/or restoration of a individual to his/her best age-appropriate functional level according to an individualized treatment plan.

The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services.

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SUPERSEDES: TN- 10-70

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AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED BELOW:

CITATION Medical and Remedial 11. Mental Health Rehabilitation Services
42 CFR Care and Services
440.130 Item 13.d. (cont'd)

Rehabilitation Services:
42 CFR 440.130(d)

4. Addiction services (cont)

Providers must maintain medical records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan.

Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

Services provided at a work site must not be job tasks oriented and must be directly related to treatment of an individual mental health needs. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institute for mental disease (IMD). Room and board is excluded from any rates provided in a residential setting. American Society of Addiction Medicine levels of care require prior approval and reviews on an ongoing basis as determined necessary by Department of Health and Hospitals to document compliance with the national standards.

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

Provider qualifications: Services are provided by licensed and unlicensed professional staff, who are at least 18 years of age with a High School or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by state law and regulations and departmentally approved guidelines and certifications. Anyone who is unlicensed providing addiction services must be registered with the Addictive Disorders Regulatory Authority and demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. State regulations require supervision of unlicensed professionals by a Qualified Professional Supervisor (QPS). A QPS includes the following professionals who are currently registered with their respective Louisiana board: licensed psychologist; licensed clinical social worker; licensed professional counselor; licensed addiction counselor; ; licensed physician and advanced practice registered nurse. The following professionals may obtain Qualified Professional Supervisor credentials; masters-prepared individual who is registered with the appropriate State Board and under the supervision of a licensed psychologist, licensed professional counselor (LPC), or licensed clinical social worker (LCSW). The QPS can provide clinical/administrative oversight and supervision of staff.

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TN# 05-34

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SUPERSEDES: TN- 05-34

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B
Item 4b, page 3

STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED
IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS
FOLLOWS:

Medical and Remedial Care Services Item 4b (cont)

2. Standards for Payment

Reimbursement is provided to chiropractors who are licensed by the State to provide
chiropractic care and services and who are enrolled in the Medicaid program as a provider.

Note: Christian Science Nurses:

Christian Science Nurses are not licensed to practice in the State.

Christian Science Sanatoria:

There are no Christian Science Sanatoria facilities in the State.

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STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED
IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS
FOLLOWS:

EPSDT Rehabilitation and Other Licensed Practitioner's Behavioral Health Services

Methods and Standards for Establishing Payment Rates

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Louisiana.

If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay Psychologists and ARNPs at 80% of the Medicaid physician rates as outlined under 4.19-B, item 5. If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay LCSWs, LPCs, LMFTs, and LAC's as well as qualified unlicensed practitioners delivering Community Psychiatric Support and Treatment at 70% of the Medicaid physician rates as outlined under 4.19-B, item 5.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Louisiana Register. The Agency's fee schedule rate was set as of March 1, 2012 and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com.

The fee development methodology will primarily be composed of provider cost modeling, though Louisiana provider compensation studies, cost data and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

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STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED
IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS
FOLLOWS:

EPSDT Rehabilitation and Other Licensed Practitioner's Behavioral Health Services

Methods and Standards for Establishing Payment Rates

Therapeutic Group Home Reimbursement

Reimbursement for the TGH is based on a Medicaid per diem reimbursement rate for unlicensed practitioners. The Medicaid per diem reimbursement rate, will be inclusive of but not limited to the allowable cost of clinical and related services, psychiatric supports, integration with community resources, and the skill-building provided by unlicensed practitioners. Final adjustments to the rate will be based on cost reports submitted by the TGH detailing the provision of Medicaid covered services to Medicaid covered beneficiaries. Licensed psychologists and LMHPs as defined in 3.1A item 4.b, Page 8a bill for their services separately under that section of the State Plan. Definitions of allowable and non-allowable costs are contained in the Provider Reimbursement Manual, CMS Publication 15-1 and OMB Circular A-87. Room and board and other non-allowable facility costs are excluded from the per diem rate. The TGH provider types and associated reimbursement are as follows:

In-State Publicly Owned and Operated Therapeutic Group Homes (TGH) Reimbursement Rates

- A. Publicly owned and operated therapeutic group homes (TGH) will be reimbursed for all reasonable and necessary costs of operation through a cost based rate that is not reconciled to 100% of the individual provider cost. The in-state publicly owned and operated TGHs will receive the Medicaid per diem reimbursement rate detailed in the In-State Privately Owned or Operated TGH section below. The rate will be subject to a retroactive adjustment. Room and board and other non-allowable facility costs are excluded from the per diem rate.

In-State Privately Owned or Operated Therapeutic Group Home (TGH) Reimbursement Rates

- A. Medicaid certified providers will be reimbursed for covered TGH services through a modeled Medicaid per diem reimbursement rate.

The Medicaid reimbursement per diem is a modeled rate using estimated allowable cost for the TGH covered services and staffing requirements. Room and board and other non-allowable facility costs are excluded from the per diem rate.

- B. Retroactive Adjustments to Rates (cost sharing): In-state privately owned and operated TGH providing covered services will also be subject to the retrospective rate adjustments. This process is part of a transitional plan to include these TGH services within the Medicaid program. The retrospective payments adjustments will be determined as follows:
1. The facilities allowable per diem cost will be determined from the Medicaid cost report submitted in accordance with the Therapeutic Group Home (TGH) Cost Reporting Requirements section of the Medicaid State Plan. The provider will receive a retrospective rate adjustment equal to 50% of the difference between the actual Medicaid allowable per diem cost and the Medicaid per diem reimbursement rate for each covered TGH patient day.
 2. The payment adjustment will not recognize provider allowable cost beyond the threshold of 125% of the initial Medicaid per diem reimbursement rate paid during each fiscal year. For example: If the initial Medicaid reimbursement rate is \$200, the maximum allowable cost recognized for rate adjustment purposes would be a \$250 per diem.
 3. Providers who have disclaimed cost reports or are non-filers will be subject to the modification of the payment adjustment as described in the Therapeutic Group Home Providers with Disclaimed Cost Reports or Non-Filer Status section of the State Plan.

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STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

EPSDT Rehabilitation and Other Licensed Practitioner's Behavioral Health Services

Methods and Standards for Establishing Payment Rates (cont)

Out-of-State Therapeutic Group Home (TGH) Reimbursement Rates

- A. Out of state therapeutic group homes will be reimbursed the lesser of their specific In-State TGH Medicaid per diem reimbursement rate, or 95% of the Louisiana Medicaid per diem reimbursement rate as detailed in the In-State Privately Owned or Operated Section above. The out-of-state TGH will not be subject to retroactive cost adjustments, or the TGH cost reporting requirement listed below.

Therapeutic Group Home (TGH) Cost Reporting Requirements

- A. All in-state Medicaid-participating therapeutic group home (TGH) providers are required to file an annual Medicaid cost report. The required cost reporting period must correspond to a calendar year basis of January 1 through December 31 for all TGH providers.
1. All providers shall submit the uniform cost report form prescribed by the Department on an annual basis. Financial information shall be based on the provider's financial records. When records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting.
 2. Cost reports shall be submitted on or before the last day of the fifth month after the end of the provider's fiscal year end.
 3. Separate cost reports must be submitted by central/home offices when costs of the central/home office are reported in the TGH provider's cost report.
 4. Failure to maintain records to support the cost report, or failure to file a timely cost report may result in penalties determined solely by DHH as described below.. Only those cost that are reported, documented and allowable per the Medicare and Medicaid provider reimbursement manual will be recognized as cost by DHH.
 5. All cost reports may be subject to an audit or desk review by the DHH audit contractor.
 6. If the TGH provider experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension request must be submitted to DHH prior to the cost report due date. Facility filing a reasonable extension request will be granted an additional 30 days to file their cost reports.

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STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED
IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS
FOLLOWS:

EPSDT Rehabilitation and Other Licensed Practitioner's Behavioral Health Services

Methods and Standards for Establishing Payment Rates (cont)

New Therapeutic Group Homes and Change of Ownership of Existing Facilities

- A. Changes of ownership (CHOW) exist if the beds of a new owner have previously been certified to participate in the Medicaid program under the previous owner's provider agreement. The acceptance of a CHOW will be determined solely by DHH. Reimbursement will continue to be based on the Medicaid reimbursement rate. The rate adjustment process will be determined using the previous owners cost report information for the applicable time periods.
- B. New providers are those entities whose beds have not previously been certified to participate in the Medicaid program. New providers will be reimbursed, depending on provider type, in accordance with the Therapeutic Group Home Unit of Service section of the State Plan.

Therapeutic Group Home Providers with Disclaimed Cost Reports or Non-Filer Status

- A. Providers with disclaimed cost reports are those providers that receive a disclaimer of opinion from the DHH audit contractor after conclusion of the audit process.
- B. Providers with non-filer status are those providers that fail to file a complete cost report in accordance with the Therapeutic Group Home (TGH) Cost Reporting Requirements section of the State Plan.
- C. Providers with disclaimed cost reports, or providers with non-filer status will not receive any additional reimbursement through the rate adjustment process. These providers will however be subject to the recoupment of Medicaid payments equal to the provider with the greatest recoupment of Medicaid payments in the State of Louisiana for the applicable fiscal year.

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STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Substance Abuse Rehabilitation Health Services

Methods and Standards for Establishing Payment Rates

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Louisiana.

If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay Psychologists and ARNPs at 80% of the Medicaid physician rates as outlined under 4.19-B, item 5. If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay LCSWs, LPCs, LMFTs, and LAC's as well as qualified unlicensed practitioners delivering substance abuse services at 70% of the Medicaid physician rates as outlined under 4.19-B, item 5.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Louisiana Register. The Agency's fee schedule rate was set as of March 1, 2012 and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com.

The fee development methodology will primarily be composed of provider cost modeling, though Louisiana provider compensation studies, cost data and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

ATTACHMENT 3.1-A
Item 9. Page 1

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED BELOW:

CITATION

42 CFR
447.304
440.130

Medical and Remedial Care and Services
Item 9

Clinic Services (Other than Hospitals)

A. Prenatal Health Care Clinics, Family Planning Clinics, End Stage Renal Disease Facilities and Radiation Therapy Centers

Clinic services are defined as diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a physician in a facility which is not part of a hospital but is organized to provide medical care to outpatients. The Bureau of Health Services Financing will make payment to private and public end stage renal disease facilities for outpatient dialysis services, radiation therapy centers for radiation therapy service, prenatal health care clinics for outpatient prenatal services, and to family planning clinics for family planning services.

Occupational therapy, recreational therapy, music therapy and art therapy are not reimbursable services under the Medicaid program.

Prenatal care provided in a prenatal health care clinic is subject to limitations on these services described in Attachment 3.1-A, Item 20.a.

EPSDT RECIPIENTS MAY BE EXCLUDED FROM SERVICE LIMITATIONS BASED ON MEDICAL NECESSITY

SUPERSEDES: TN- 00-13

STATE	<u>Louisiana</u>
DATE REQ'D	<u>3-10-11</u>
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A

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