RULE

Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Behavioral Health

Adult Mental Health Services
Covered Services and Recipient Qualifications
(LAC 50:XXXIII.Chapters 61-67)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 61-67 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

TITLE 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services
Subpart 7. Adult Mental Health Services

Chapter 61. General Provisions

§6101. Introduction

A. The Medicaid Program provides coverage under the Medicaid State Plan for mental health services rendered to adults with mental health disorders. These services shall be administered under the authority of the Department of Health and Hospitals, in collaboration with the managed care organizations (MCOs), which shall be responsible for the necessary operational

and administrative functions to ensure adequate service coordination and delivery.

B. The mental health services rendered to adults shall be necessary to reduce the disability resulting from mental illness and to restore the individual to his/her best possible functioning level in the community.

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 38:358 (February 2012), LR 42:

§6103. Recipient Qualifications

A. Individuals, 21 years of age and older, who meet Medicaid eligibility and clinical criteria established in §6103.B, shall qualify to receive adult mental health services.

B. Qualifying individuals shall be eligible to receive the following adult mental health services.

1. Licensed mental health professional services are available to adults enrolled in Bayou Health, provided the services are determined to be medically necessary in accordance with LAC 50:I.1101.

a. - b. Repealed.

2. Mental health rehabilitation services are available to adults enrolled in Bayou Health, provided the

services are determined to be medically necessary in accordance with LAC 50:I.1101, and the enrollee meets the following conditions:

a. currently presents with mental health symptoms that are consistent with a diagnosable mental disorder specified within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* or the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10)*;

i. – iii. Repealed.

b. has at least a score of two on the Level of Care Utilization System (LOCUS); and

c. has a condition for which services are therapeutically appropriate.

3. – 4. Repealed.

C. An adult who has previously met the criteria stated in §6103.B.2.a-c, but who now meets a composite LOCUS score of one and needs subsequent medically necessary services for stabilization and maintenance, shall be eligible for adult mental health services.

D. An adult with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for mental health rehabilitation 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 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:

Chapter 63. Services

§6301. General Provisions

A. All mental health services must be medically necessary, in accordance with the provisions of LAC 50:I.1101. The medical necessity for services shall be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law.

B. …

C. There shall be recipient involvement throughout the planning and delivery of services.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall be appropriate for:

a. age;

b. development; and

c. education.

4. Repealed.

D. Anyone providing mental health services must operate within their scope of practice license.

E. …

F. Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the plan of care. Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the department.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:

§6303. Assessments

A. For mental health rehabilitation services, each enrollee shall be assessed and have a plan of care (POC) developed.

B. Assessments shall be performed by a licensed mental health practitioner (LMHP).

C. Assessments must be performed at least every 365 days or as needed any time there is a significant change to the enrollee's circumstances.

D. Repealed.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:

§6305. Plan of Care

A. Each enrollee who receives adult mental health rehabilitation services shall have a POC developed based upon the assessment.

B. The individualized POC shall be developed according to the criteria established by the department and in accordance

with the provisions of this Rule, the provider manual and other notices or directives issued by the department.

1. The POC is reviewed at least every 365 days and as needed when there is significant change in the individual's circumstances.

C. The plan of care shall be developed by a case manager who acts as an advocate for the individual and is a source of information for the individual and the team.

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 38:359 (February 2012), LR 42:

§6307. Covered Services

A. The following mental health services shall be reimbursed under the Medicaid Program:

1. therapeutic services, including diagnosis and treatment delivered by LMHPs;

2. – 3. …

B. Service Exclusions. The following shall be excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;

2. services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs; and

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

C. - C.4. Repealed.

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 38:359 (February 2012), LR 42:

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. Each provider of adult mental health services shall enter into a contract with one or more of the managed care organizations 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. The provider shall create and maintain documents to substantiate that all requirements are met.

C. Providers of adult mental health 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 adult mental health services must be certified by the department, or its designee, in addition to operating within their scope of practice license.

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

1. a copy of the plan of care and treatment plan;

2. – 5. …

6. the goals of the plan of care and/or treatment plan.

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), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:

Chapter 67. Reimbursement

§6701. Reimbursement Methodology

A. Effective for dates of service on or after December 1, 2015, the department, or its fiscal intermediary, shall make monthly capitation payments to the MCOs.

B. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

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), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Facility Need Review
Outpatient Abortion Facilities
(LAC 48:I.Chapter 125)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 48:I.12501 and §12503 and to repeal §12524 in the Medical Assistance Program as authorized by R.S. 36:254. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48

PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 5. Health Planning

Chapter 125. Facility Need Review

Subchapter A. General Provisions

§12501. Definitions

A. ...

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Outpatient Abortion Facility–Repealed.

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AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), LR 34:2611 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2437 (November 2009), LR 36:323 (February 2010), LR 38:1961 (August 2012), LR 41:135 (January 2015), LR 42:

§12503. General Information

A. – B. ...

C. The department will also conduct a FNR for the following provider types to determine if there is a need to license additional units, providers or facilities:

1. - 3. ...

4. hospice providers or inpatient hospice facilities; and

5. pediatric day health care facilities.

6. Repealed.

D. – F.4. ...

G. Additional Grandfather Provision. An approval shall be deemed to have been granted under FNR without review for HCBS providers, ICFs/ID, ADHC providers, hospice providers, and pediatric day health care centers that meet one of the following conditions:

1. - 3. ...

4. hospice providers that were licensed, or had a completed initial licensing application submitted to the department, by March 20, 2012; or

5. pediatric day health care providers that were licensed by the department before March 1, 2014, or an entity that meets all of the following requirements:

a. has a building site or plan review approval for a PDHC facility from the Office of State Fire Marshal by March 1, 2014;

b. has begun construction on the PDHC facility by April 30, 2014, as verified by a notarized affidavit from a licensed architect submitted to the department, or the entity had a fully executed and recorded lease for a facility for the specific use as a PDHC facility by April 30, 2014, as verified by a copy of a lease agreement submitted to the department;

c. submits a letter of intent to the department's Health Standards Section by April 30, 2014, informing the department of its intent to operate a PDHC facility; and

d. becomes licensed as a PDHC by the department no later than December 31, 2014.

6. - 6.d. Repealed.

H. - H.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), amended LR 35:2437 (November 2009), LR 36:323 (February 2010), LR 38:1961 (August 2012), LR 41:136 (January 2015), LR 42:

Subchapter B. Determination of Bed, Unit, Facility or Agency Need

§12524. Outpatient Abortion Facilities

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1961 (August 2012), repealed LR 42:

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Service Financing
and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Residential Options Waiver
Reserved Capacity Group
(LAC 50:XXI.16107,16343,16701 and 16901)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.16107, §16343, §16701 and §16901 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 13. Residential Options Waiver

Chapter 161. General Provisions

§16107. Programmatic Allocation of Waiver Opportunities

A. – C. ...

D. Individuals with intellectual and developmental disabilities (I/DD) who have a statement of approval (SOA) through the Office for Citizens with Developmental Disabilities

(OCDD), and who currently receive services via the Office of Aging and Adult Services (OAAS) Community Choices Waiver (CCW) or Adult Day Health Care (ADHC) Waiver programs shall be placed in a reserved capacity group to allow for transition into the ROW.

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, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), LR 42:

Chapter 163. Covered Services

§16343. Adult Day Health Care Services

A. Adult day health care (ADHC) services shall be furnished as specified in the POC and at an ADHC facility in a non-institutional, community-based setting encompassing health, medical, and social services needed to ensure the optimal functioning of the participant.

B. ADHC services include:

1. transportation between the participant's place of residence and the ADHC, in accordance with licensing standards;

2. assistance with activities of daily living;

3. health and nutrition counseling;

4. an individualized exercise program;

5. an individualized goal-directed recreation program;

6. health education classes;

7. individualized health/nursing services; and

8. meals.

a. Meals shall not constitute a full nutritional regimen (three meals per day), but shall include a minimum of two snacks and a hot, nutritious lunch.

C. The number of participants included in the service per day shall be determined by the facility's licensed capacity and attendance. The average capacity per facility is 49 participants.

D. Nurses shall be involved in the participant's service delivery as specified in the POC or as needed. The ADHC shall develop an individualized service plan based on the participant's POC. If the individualized service plan requires certain health and nursing services, the nurse on staff shall ensure that the services are delivered while the participant is at the ADHC facility.

E. ADHC services shall be provided no more than 10 hours per day and no more than 50 hours per week.

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 and the Office for Citizens with Developmental Disabilities, LR 42:

Chapter 167. Provider Participation

§16701. General Provisions

A. - F. ...

G. Providers of ADHC services must:

1. be licensed as ADHC providers by the state of Louisiana in accordance with R.S. 40:2120.41-2120.47;

2. comply with all of the department's rules and regulations; and

3. be enrolled as an ADHC provider with the Medicaid program.

a. ADHC facility staff shall meet the requirements of department rules and regulations, as well as state licensing provisions.

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, Office for Citizens with Developmental Disabilities, LR 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2168 (October 2015), LR 42:

Chapter 169. Reimbursement

§16901. Reimbursement Methodology

A. – A.5.f. ...

6. support coordination;

7. – 7.a. ...

b. micro-enterprise; and

8. adult day health care.

B. – L.1.d. ...

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, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:1049 (April 2013), LR 41:2168 (October 2015), LR 42:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Non-State Governmental Organizations
Supplemental Payments
(LAC 50:II.20029)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:II.20029 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20029. Supplemental Payments

A. Non-State Governmental Organization Nursing Facilities

1. Effective for dates of service on or after January 20, 2016, any nursing facility that is owned or operated by a non-state governmental organization (NSGO), and that has entered into an agreement with the department to participate, shall qualify for a Medicaid supplemental payment adjustment, in addition to the uniform Medicaid rates paid to nursing facilities. The only qualifying nursing facilities effective for January 20, 2016 are:

a. Gueydan Memorial Guest Home;

b. Lane Memorial Hospital Geriatric Long-Term Care (LTC);

c. LaSalle Nursing Home;

d. Natchitoches Parish Hospital LTC Unit; and

e. St. Helena Parish Nursing Home.

2. The supplemental Medicaid payment to a non-state, government-owned or operated nursing facility shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272.

3. Payment Calculations. The Medicaid supplemental payment adjustment shall be calculated as follows. For each state fiscal year (SFY), the Medicaid supplemental payment shall be calculated as the difference between:

a. the amount that the department reasonably estimates would have been paid to nursing facilities that are owned or operated by a NSGO using the Medicare resource utilization groups (RUGs) prospective payment system. For each Medicaid resident that is in a nursing facility on the last day of a calendar quarter, the minimum data set (MDS) assessment that is in effect on that date is classified using the Medicare RUGs system. The Medicare rate applicable to the Medicare RUG, adjusted by the Medicare geographic wage index, equals the Medicaid resident's estimated Medicare rate. A simple average Medicare rate is determined for each nursing facility by summing the estimated Medicare rate for each Medicaid resident in the facility and dividing by total Medicaid residents in the facility; and

b. the Medicaid per diem rate for nursing

facilities that are owned or operated by a NSGO. The Medicaid rate shall be adjusted to include laboratory, radiology, and pharmacy services to account for program differences in services between Medicaid and Medicare. The statewide average of laboratory, radiology, and pharmacy services is calculated using Medicaid cost report data.

4. Each participating nursing facility's upper payment limit (UPL) gap shall be determined as the difference between the estimated Medicare rate calculated in §20029.A.3.a and the adjusted Medicaid rate calculated in §20029.A.3.b.

a. Each facility's UPL gap is multiplied by the Medicaid days to arrive at its supplemental payment amount. Medicaid days are taken from the Medicaid cost report.

5. Frequency of Payments and Calculations

a. For each calendar quarter, an estimated interim supplemental payment will be calculated as described in this Section utilizing the latest Medicare RUGs and payment rates and Medicaid cost reports and available Medicaid payment rates. Payments will be made to each nursing facility that is owned or operated by a NSGO and that has entered into an agreement with the department to participate in the supplemental payment program.

b. Following the completion of the state's fiscal year, the final supplemental payment amount for the state fiscal year just ended will be calculated. These calculations will be based on the final Medicare RUGs and payment rates and the most recently reviewed Medicaid cost reports and Medicaid payment rates

that cover the just ended state fiscal year period. The final supplemental payment calculations will be compared to the estimated interim supplemental payments, and the difference, if positive, will be paid to the NSGO, and if negative, collected from the NSGO.

6. No payment under this Section is dependent on any agreement or arrangement for provider or related entities to donate money or services to a governmental entity.

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 42:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert

Secretary