RULE

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

Behavioral Health Services
Louisiana Bayou Health and
Coordinated System of Care Waiver
(LAC 50:XXXIII.Chapters 1-9)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 1-9 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 1. Louisiana Bayou Health and Coordinated System of Care Waiver

Chapter 1. Managed Care Organizations and Coordinated System of Care Contractor

§101. General Provisions

A. The Medicaid Program hereby adopts provisions to establish a comprehensive system of delivery for specialized behavioral health and physical health services. These services shall be administered through the Louisiana Bayou Health and

Coordinated System of Care (CSoC) Waiver under the authority of the Department of Health and Hospitals (DHH), in collaboration with managed care organizations (MCOs) and the coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The provisions of this Rule shall apply only to the services provided to Medicaid recipients/enrollees by or through an MCO or the CSoC contractor.

C. Managed care organizations shall operate as such, and the CSoC contractor shall operate as a prepaid inpatient health plan (PIHP). The MCOs were procured through a competitive request for proposal (RFP) process. The CSoC contractor was procured through an emergency process consistent with 45 CFR part 92. The MCOs and CSoC contractor shall assist with the state's system reform goals to support individuals with behavioral health and physical health needs in families, homes, communities, schools, and jobs.

D. Through the utilization of MCOs and the CSoC contractor, it is the department's goal to:

1. – 4. …

E. The CSoC contractor shall be paid on a non-risk basis for specialized behavioral health services rendered to children/youth enrolled in the Coordinated System of Care

Waiver. The MCOs shall be paid on a risk basis for specialized behavioral health and physical health services rendered to adults and children/youth.

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:

§103. Recipient Participation

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

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

2. aged and related populations, age 65 and older who are not blind, do not have a disability, and are not members of the §1931 adult population;

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

4. children with special health care needs as defined in §1932(a);

5. Native Americans;

6. full dual eligibles (for behavioral health services only);

7. children residing in an intermediate care facility for persons with developmental disabilities (for behavioral health services only);

a. – b. Repealed.

8. all enrollees of waiver programs administered by the DHH Office for Citizens with Developmental Disabilities (OCDD) or the DHH Office of Aging and Adult Services (OAAS) (mandatory for behavioral health services only);

9. all Medicaid children functionally eligible for the CSoC;

10. adults residing in a nursing facility (for behavioral health services only);

11. supplemental security income/transfer of resources/long-term care related adults and children (for behavioral health services only); and

12. transfer of resources/long-term care adults and children (for behavioral health services only).

NOTE: Recipients qualifying for retroactive eligibility are enrolled in the waiver.

B. Mandatory participants shall be automatically enrolled and disenrolled from the MCOs or the CSoC contractor.

C. Notwithstanding the provisions of Subsection A of this Section, the following Medicaid recipients are excluded from enrollment in the MCOs and the CSoC contractor:

1. – 3. …

4. recipients of refugee medical assistance;

5. recipients enrolled in the Spend-Down Medically Needy Program;

6. – 7. …

8. recipients enrolled in the Take Charge Plus Program;

9. recipients enrolled in the Greater New Orleans Community Health Connection (GNOCHC) program; and

10. recipients enrolled in the Long-Term Care Medicare Co-Insurance program.

D. Any Medicaid eligible person is suspended from participation during a period of incarceration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:1286 (July 2015), LR 41:

§105. Enrollment Process

A. The MCOs and the CSoC contractor shall abide by all enrollment and disenrollment policies and procedures as outlined in the contract entered into by department.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§107. Enrollee Rights and Responsibilities

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

1. – 2. …

3. appeal an MCO and CSoC contractor decision through the MCO's and CSoC contractor's internal process and/or the state fair hearing process;

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

5. – 8. …

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

1. informing their MCO or CSoC contractor of the loss or theft of their Medicaid identification card;

2. …

3. being familiar with their MCO's or CSoC contractor's procedures to the best of his/her abilities;

4. contacting their MCO or CSoC contractor, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified;

5. – 7. …

8. accessing services only from specified providers contracted with their MCO or CSoC contractor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:361 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 3. Managed Care Organizations and the Coordinated System of Care Contractor Participation

§301. Participation Requirements and Responsibilities

A. In order to participate in the Medicaid Program, an MCO and the CSoC contractor shall execute a contract with the department, and shall comply with all of the terms and conditions set forth in the contract.

B. MCOs and the CSoC contractor shall:

1. manage contracted services;

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

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

a. Repealed.

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

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

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

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

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

9. ensure that treatment plans or plans of care meet the following requirements:

a. are developed by the enrollee's primary care provider (PCP) with the enrollee's participation and in consultation with any specialists' providing care to the enrollee, with the exception of treatment plans or plans of care developed for recipients in the Home and Community Based Services (HCBS) Waiver. The wraparound agency shall develop plans of care according to wraparound best practice standards

for recipients who receive behavioral health services through the HCBS Waiver;

b. are approved by the MCO or CSoC contractor in a timely manner, if required;

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

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

10. ensure that Medicaid recipients/enrollees receive information:

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

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

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

11 – 12 .c. 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 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§303. Benefits and Services

A. Benefits and services shall be rendered to Medicaid recipients/enrollees as provided under the terms of the contract and department-issued guidelines.

B. The MCO and CSoC contractor:

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

2. – 3.b. …

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

C. The benefits and services provided to enrollees shall include, but are not limited to, those services specified in the contract between the MCOs and the CSoC contractor and the department.

1. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§305. Service Delivery

A. The MCOs and CSoC contractor shall ensure that services rendered to enrollees are medically necessary, are authorized or coordinated, and are provided by professionals according to their scope of practice and licensing in the state of Louisiana.

B. …

C. MCOs shall offer a contract to all federally qualified health centers (FQHCs), rural health clinics (RHCs), and tribal clinics. Enrollees shall have a choice of available providers in the plan's network to select from. The CSoC contractor shall be required to contract with at least one FQHC in each medical practice region of the state (according to the practice patterns within the state) if there is an FQHC which can provide substance use disorder services or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications.

D. MCOs and the CSoC contractor shall ensure that the recipient is involved 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 5. Reimbursement

§501. General Provisions

A. For recipients enrolled with the CSoC contractor, reimbursement for services shall be based upon the established Medicaid fee schedule for specialized behavioral health services.

B. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs. 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.

C. 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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013), LR 41:

§503. Reimbursement Methodology (Reserved)

Chapter 7. Grievance and Appeals Process

§701. General Provisions

A. The MCOs and the CSoC contractor shall be required to have an internal grievance system and internal appeal process. The appeal process allows a Medicaid recipient/enrollee to

challenge a decision made, a denial of coverage, or a denial of payment for services.

B. – C. …

D. An enrollee must exhaust the MCO or the CSoC contractor grievance and appeal process before requesting a state fair hearing.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 9. Monitoring Activities

§901. General Provisions

A. The contracted MCOs and the CSoC contractor shall be accredited by an accrediting body that is designated in the contract, or agrees to submit an application for accreditation at the earliest possible date as allowed by the accrediting

body. Once accreditation is achieved, it shall be maintained through the life of this agreement.

B. The MCOs and CSoC contractor shall be required to track grievances and appeals, network adequacy, access to services, service utilization, quality measure and other monitoring and reporting requirements in accordance with the contract with the department.

C. – G. 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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

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
and
Office of Behavioral Health

Behavioral Health Services
Substance Use Disorders Services
(LAC 50:XXXIII.Chapters 141-147)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 141-147 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 15. Substance Use Disorders Services

Chapter 141. General Provisions

§14101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for substance use disorders (SUD) services rendered to children and adults. These services shall be administered under the authority of the Department of Health and Hospitals, in collaboration with managed care organizations (MCOs) and the coordinated system

of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery. The CSoC contractor shall only manage specialized behavioral health services for children/youth enrolled in the CSoC program.

B. The SUD services rendered shall be those services which are medically necessary to reduce the disability resulting from the 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 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§14103. Recipient Qualifications

A. Children and adults who meet Medicaid eligibility and clinical criteria shall qualify to receive medically necessary SUD services.

B. Qualifying children and adults with an identified SUD diagnosis shall be eligible to receive SUD services covered under the Medicaid State 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 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 143. Services

§14301. General Provisions

A. …

B. SUD services are subject to prior approval by the MCO or the CSoC contractor.

C. – D. …

1. The agency or individual who has the decision making authority for a child or adolescent in state custody must approve the provision of services to the recipient.

E. Children who are in need of SUD services shall be served within the context of the family and not as an isolated unit.

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 also be appropriate for:

a. age;

b. development; and

c. education.

4. Repealed.

F. …

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 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§14303. Covered Services

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

A.1. – B.2. ...

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;

4. – 5. ...

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 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 145. Provider Participation

§14501. Provider Responsibilities

A. Each provider of SUD services shall enter into a contract with one or more of the MCOs or 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. Providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes.

C. Providers of SUD 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 SUD 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.

E. Residential addiction treatment facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to the MCO or CSoC contractor in writing within the time limit established by the department.

F. – F.6. …

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 147. Reimbursement

§14701. General Provisions

A. For recipients enrolled with the CSoC contractor, reimbursement for services shall be based upon the established Medicaid fee schedule for SUD services.

B. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs. 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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:3301 (December 2013), LR 41:

§14703. Reimbursement Methodology

A. Effective for dates of service on or after July 1, 2012, the reimbursement rates for outpatient SUD services provided to children/adolescents shall be reduced by 1.44 percent of the rates in effect on June 30, 2012.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

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
and
Office of Behavioral Health

Children's Behavioral Health Services
(LAC 50:XXXIII. Chapters 21-27)

The Department of Health and Hospitals, Bureau of Health Services Financing and Office of Behavioral Health have amended LAC 50:XXXIII Chapters 21-27 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 3. Children's Mental Health Services

Chapter 21. General Provisions

§2101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for mental health services rendered to children and youth with behavioral health disorders. These services shall be administered under the authority of the Department of Health and Hospitals, in collaboration with managed care organizations (MCOs) and the coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate

service coordination and delivery. The CSoC contractor shall only manage specialized behavioral health services for children/youth enrolled in the coordinated system of care.

B. The specialized behavioral health services rendered to children with emotional or behavioral disorders are those services necessary to reduce the disability resulting from the 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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 23. Services

§2301. General Provisions

A. All specialized behavioral health services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health practitioner (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law.

B. All services shall be authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

C. – C.1. …

D. Children who are in need of specialized behavioral health services shall be served within the context of the family and not as an isolated unit.

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 children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

4. Repealed.

E. – F. …

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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§2303. Covered Services

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

1. therapeutic services delivered by licensed mental health professionals (LMHP), including diagnosis and treatment;

2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation;

3. crisis intervention services; and

4. crisis stabilization services.

B. Service Exclusions. The following services 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;

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;

4. services rendered in an institute for mental disease; and

5. the cost of room and board associated with crisis stabilization.

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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 25. Provider Participation

§2501. Provider Responsibilities

A. Each provider of specialized behavioral health services shall enter into a contract with one or more of the MCOs and with the CSoC contractor for youth enrolled in the Coordinated System of Care program in order to receive reimbursement for Medicaid covered services.

B. …

C. Providers of specialized behavioral 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 specialized 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 or treatment plan;

2. – 5. …

6. the goals of the plan of care 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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 27. Reimbursement

§2701. General Provisions

A. For recipients enrolled with the CSoC contractor, reimbursement for services shall be based upon the established Medicaid fee schedule for specialized behavioral health services.

B. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs. The capitation rates paid to 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.

1. – 3. 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 38:365 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013), LR 41:

§2703. Reimbursement Methodology

A. Effective for dates of service on or after July 1, 2012, the reimbursement rates for the following behavioral health services provided to children/adolescents shall be reduced by 1.44 percent of the rates in effect on June 30, 2012:

1. therapeutic services;

2. rehabilitation services; and

3. crisis intervention 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 and the Office of Behavioral Health, LR 41:

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

Free-Standing Birthing Centers
(LAC 50:XV Chapters 265-271)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:XV Chapters 265-271 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 XV. Services for Special Populations
Subpart 18. Free-Standing Birthing Centers

Chapter 265. General Provisions

§26501. Purpose

A. The Medicaid Program shall provide coverage and reimbursement for labor and delivery services rendered by free-standing birthing centers (FSBCs). Stays for delivery at the FSBC are typically less than 24 hours and the services rendered for labor and delivery are very limited in comparison to delivery services rendered during inpatient hospital stays.

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 41:

§26503. Definitions

Birthing Center–a facility, for the primary purpose of performing low-risk deliveries, that is not a hospital or licensed as part of a hospital, where births are planned to occur away from the mother's usual residence following a low-risk pregnancy.

Low-Risk Pregnancy–a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care and the anticipation of a normal, uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

Surrounding Hospital–a hospital located within a 20 mile radius of the birthing center in urban areas and within a 30 mile radius of the birthing center in rural areas.

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 41:

Chapter 267. Services

§26701. Scope of Services

A. Free-Standing birthing centers shall be reimbursed for labor and low-risk delivery services provided to Medicaid eligible pregnant women by an obstetrician, family practitioner, certified nurse midwife, or licensed midwife. FSBC services are appropriate when a normal, uncomplicated labor and birth is anticipated.

B. Services shall be provided by the attending practitioner from the time of the pregnant woman's admission through the birth and the immediate postpartum period.

C. Service Limitation. FSBC staff shall not administer general or epidural anesthesia 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 41:

Chapter 269. Provider Participation

§26901. General Provisions

A. In order to enroll to participate in the Louisiana Medicaid Program as a provider of labor and delivery services, the FSBC must:

1. be accredited by the Commission for Accreditation of Birth Centers; and

2. be approved/certified by the Medicaid medical director.

B. The FSBC shall be located within a ground travel time distance from a general acute care hospital with which the FSBC shall maintain a contractual relationship, including a transfer agreement, that allows for an emergency caesarian delivery to begin within 30 minutes of the decision a caesarian delivery is necessary.

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 41:

§26903. Staffing Requirements

A. The FSBC shall have on staff:

1. a licensed obstetrician, family practitioner, certified nurse midwife, or licensed midwife who shall attend each woman in labor from the time of admission through birth and the immediate postpartum period.

a. A licensed midwife providing birthing services within the FSBC must:

i. have passed the national certification exam through the North American Registry of Midwives; and

ii. hold a current, unrestricted state license with the Louisiana State Board of Medical Examiners.

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 41:

Chapter 271. Reimbursement

§27101. Reimbursement Methodology

A. Effective for dates of service on or after November 20, 2015, a FSBC shall be reimbursed a one-time payment for labor and delivery services at a rate equal to 90 percent of the average per diem rates of surrounding hospitals providing the same services.

1. Attending physicians shall be reimbursed for birthing services according to the published fee schedule rate for physician services rendered in the Professional Services Program.

2. Certified nurse midwives providing birthing services within a FSBC shall be reimbursed at 80 percent of the published fee schedule rate for physician services rendered in the Professional Services Program.

3. Licensed midwives providing birthing services within a FSBC shall be reimbursed at 75 percent of the published fee schedule rate for physician services in the Professional Services Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

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
and
Office of Behavioral Health

Home and Community-Based Behavioral Health Services Waiver
(LAC 50:XXXIII.Chapters 81-85)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 81-85 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 9. Home and Community-Based Services Waiver

Chapter 81. General Provisions

§8101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for behavioral health services rendered to children with mental illness and severe emotional disturbances (SED) by establishing a home and community-based services (HCBS) waiver. This HCBS waiver shall be administered under the authority of the Department of Health and Hospitals, in collaboration with the coordinated system of

care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. – C. …

D. Local wraparound agencies will be the locus of treatment planning for the provision of all services. Wraparound agencies are the care management agencies for the day-to-day operations of the waiver in the parishes they serve. The wraparound agencies shall enter into a contract with the CSoC contractor and are responsible for the treatment planning for the HCBS waiver in their areas, in accordance with 42 CFR 438.208(c).

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:

§8103. Recipient Qualifications

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

1. …

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;

A.4. – B. …

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:

Chapter 83. Services

§8301. General Provisions

A. – C. …

1. The agency or individual who has the decision making authority for a child or adolescent in state custody must approve the provision of services to the recipient.

D. Children who are in need of behavioral health services shall be served within the context of the family and not as an isolated unit.

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 children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

4. Repealed.

E. – G.1.f. …

2. The family member must become an employee of the provider agency or contract with the CSoC contractor and must meet the same standards as direct support staff that are not related to the individual.

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 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§8303. Service Plan Development

A. The wraparound facilitator is responsible for convening the child and family team to develop the initial waiver specific plan of care within 30 days of receipt of referral from the managed care organization.

B. If new to the system, the recipient will be receiving services based upon the preliminary plan of care (POC) while the wraparound process is being completed.

C. …

D. The wraparound agency will facilitate development and implementation of a transition plan for each recipient beginning at the age of 15 years old, as he/she approaches adulthood.

E. …

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 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§8305. Covered Services

A. The following behavioral health services shall be provided in the HCBS waiver program:

1. short-term respite care;

2. independent living/skills building;

3. youth support and training; and

4. parent support and training.

5. – 7. Repealed.

B. Service Limitations

1. – 2. …

3. Repealed.

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

1. – 2. …

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; and

4. services rendered in an institution for mental disease.

5. 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 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

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. – C. …

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. – 5. …

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:

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

Managed Care for Physical and Basic Behavioral Health
Behavioral Health Integration
(LAC 50:I.Chapters 31-37)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:I.Chapters 31-40 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 I. Administration
Subpart 3. Managed Care for Physical and Basic Behavioral Health

Chapter 31. General Provisions

§3101. Introduction

A. – A.5. ...

B. Effective for dates of service on or after December 1, 2015, the department will operate a managed care delivery system for an expanded array of services to include comprehensive, integrated physical and behavioral health (basic and specialized) services, named the Bayou Health program, utilizing one model, a risk bearing managed care organization (MCO), hereafter referred to as an "MCO".

C. It is the department's intent to procure the provisions of healthcare services statewide to Medicaid enrollees participating in the Bayou Health program from risk bearing MCOs through the competitive bid process.

1. The number of MCOs shall be no more than required to meet the Medicaid enrollee capacity requirements and ensure choice for Medicaid recipients as required by federal statute.

D. – D.1. 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 37:1573 (June 2011), amended LR 41:928 (May 2015), LR 41:

§3103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in coordinated care networks:

1. mandatory enrollees:

a. children up to 19 years of age who are eligible under §1902 and §1931 of the Social Security Act (hereafter referred to as the Act) as poverty-level related groups and optional groups of older children;

b. parents and caretaker relatives who are eligible under §1902 and §1931 of the Act;

c. Children's Health Insurance Program (CHIP) (title XXI) children enrolled in Medicaid expansion program (LaCHIP Phase I, II, III);

d. CHIP (title XXI) prenatal care option (LaCHIP Phase IV) and children enrolled in the separate, stand-alone CHIP program (LaCHIP Phase V);

e. pregnant women whose basis for eligibility is pregnancy, who are only eligible for pregnancy-related services, and whose eligibility extends until 60 days after the pregnancy ends;

f. non-dually eligible aged, blind, and disabled adults over the age of 19;

g. uninsured women under the age of 65 who have been screened through the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program and identified as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer, and are not otherwise eligible for Medicaid;

h. individuals eligible through the Tuberculosis Infected Individual Program;

i. former foster care children eligible under §1902(a)(10)(A)(i)(IX) and (XVII) of the Act; or

i. – v. Repealed.

j. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program.

2. – 3. Repealed.

B. Mandatory, Voluntary Opt-In Participants

1. Participation in an MCO for the following participants is mandatory for specialized behavioral health and non-emergency medical transportation (NEMT) services only, and is voluntary for physical health services:

a. individuals who receive services under the authority of the following 1915(c) home and community-based services waivers; and

i. Adult Day Health Care (ADHC) waiver;

ii. Community Choices Waiver (CCW);

iii. New Opportunities Waiver (NOW);

iv. Children's Choice (CC) waiver;

v. Residential Options Waiver (ROW); and

vi. Supports Waiver (SW);

b. individuals under the age of 21 who are otherwise eligible for Medicaid, and who are listed on the DHH Office for Citizens with Developmental Disabilities' Request for Services Registry. These children are identified as *Chisholm* class members:

i. ...

ii. Repealed.

C. Mandatory, voluntary opt-in populations may initially elect to receive physical health services through Bayou Health at any time.

D. Mandatory, voluntary opt-in populations who elected to receive physical health services through Bayou Health, but returned to legacy Medicaid for physical health services, may return to Bayou Health for physical health services only during the annual open enrollment period.

1. – 1.f. Repealed.

E. Mandatory MCO Populations - Specialized Behavioral Health Services Only

1. The following populations are mandatory enrollees in Bayou Health for specialized behavioral health services only:

a. individuals residing in nursing facilities; and

b. individuals under the age of 21 residing in intermediate care facilities for persons with intellectual disabilities (ICF/ID).

F. Mandatory MCO Populations – Specialized Behavioral Health and NEMT Services Only

1. Individuals who receive both Medicare and Medicaid (e.g. Medicaid dual eligibles) are mandatory enrollees in Bayou

Health for specialized behavioral health and non-emergency medical transportation services only.

G. The enrollment broker will ensure that all participants are notified at the time of enrollment that they may request dis-enrollment from the MCO at any time for cause.

H. Participation Exclusion

1. The following Medicaid and/or CHIP recipients are excluded from participation in an MCO and cannot voluntarily enroll in an MCO. Individuals who:

a. reside in an ICF/ID (adults);

b. are partial dual eligibles;

c. receive services through the Program for All-Inclusive Care for the Elderly (PACE);

d. have a limited period of eligibility and participate in either the Spend-Down Medically Needy Program or the Emergency Services Only program;

e. receive services through the Take Charge Plus program; or

f. are participants in the Greater New Orleans Community Health Connection (GNOCHC) Waiver program.

I. The department reserves the right to institute a medical exemption process for certain medically high risk recipients that may warrant the direct care and supervision of a non-primary care specialist on a case by case basis.

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 36:2465 (November 2010), LR 37:680 (February 2011)], LR 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014), LR 40:2258 (November 2014), LR 41:929 (May 2015), LR 41:

§3105. Enrollment Process

A. – C.3. ...

D. Special Open Enrollment Period for Specialized Behavioral Health Integration

1. The department, through its enrollment broker, will provide an opportunity for all populations to be mandatorily enrolled into Bayou Health for specialized behavioral health services. These populations will be given a 60-day choice period to proactively choose an MCO.

2. Each potential MCO member shall receive information and the offer of assistance with making informed choices about the participating MCOs and the availability of choice counseling.

a. - b. Repealed.

3. During the special enrollment period, current members who do not proactively request reassignment will remain with their existing MCO.

4. These new members will be encouraged to make a choice among the participating MCOs. When no choice is made, auto-assignment will be used as outlined in §3105.G.2.a.

E. Special Enrollment Provisions for Mandatory, Opt-In Population Only

1. Mandatory, opt-in populations may request participation in Bayou Health for physical health services at any time. The effective date of enrollment shall be no later than the first day of the second month following the calendar month the request for enrollment is received. Retroactive begin dates are not allowed.

2. The enrollment broker will ensure that all mandatory, opt-in populations are notified at the time of enrollment of their ability to disenroll for physical health at any time. The effective date will be the first day of a month, and no later than the first day of the second month following the calendar month the request for disenrollment is received.

a. – a.i. Repealed.

3. Following an opt-in for physical health and selection of an MCO and subsequent 90-day choice period, these members will be locked into the MCO for 12 months from the effective date of enrollment or until the next annual enrollment period unless they elect to disenroll from physical health.

4. – 5.b. Repealed.

F. Enrollment of Newborns. Newborns of Medicaid eligible mothers, who are enrolled at the time of the newborn's birth, will be automatically enrolled with the mother’s MCO, retroactive to the month of the newborn’s birth.

1. If there is an administrative delay in enrolling the newborn and costs are incurred during that period, the member shall be held harmless for those costs and the MCO shall pay for these services.

a. – c. Repealed.

2. The MCO and its providers shall be required to:

a. report the birth of a newborn within 48 hours by requesting a Medicaid identification (ID) number through the department’s online system for requesting Medicaid ID numbers; and

b. complete and submit any other Medicaid enrollment form required by the department.

2.c. – 3. Repealed.

G. Selection of an MCO

1. As part of the eligibility determination process, Medicaid and LaCHIP applicants, for whom the department determines eligibility, shall receive information and assistance with making informed choices about participating MCOs from the enrollment broker. These individuals will be afforded the opportunity to indicate the plan of their choice on their Medicaid financial

application form or in a subsequent contract with the department prior to determination of Medicaid eligibility.

a. – c. Repealed.

2. All new recipients who have made a proactive selection of an MCO shall have that MCO choice transmitted to the enrollment broker immediately upon determination of Medicaid or LaCHIP eligibility. The member will be assigned to the MCO of their choosing unless the plan is otherwise restricted by the department.

a. Recipients who fail to choose an MCO shall be automatically assigned to an MCO by the enrollment broker, and the MCO shall be responsible to assign the member to a primary care provider (PCP) if a PCP is not selected at the time of enrollment into the MCO.

b. For mandatory populations for all covered services as well as mandatory, specialized behavioral health populations, the auto-assignment will automatically enroll members using a hierarchy that takes into account family/household member enrollment, or a round robin method that maximizes preservation of existing specialized behavioral health provider-recipient relationships.

3. All new recipients shall be immediately, automatically assigned to an MCO by the enrollment broker if they

did not select an MCO during the financial eligibility determination process.

4. All new recipients will be given 90 days to change plans if they so choose.

5. The following provisions will be applicable for recipients who are mandatory participants.

a. If there are two or more MCOs in a department designated service area in which the recipient resides, they shall select one.

b. Recipients may request to transfer out of the MCO for cause and the effective date of enrollment into the new plan shall be no later than the first day of the second month following the calendar month that the request for disenrollment is filed.

H. Automatic Assignment Process

1. The following participants shall be automatically assigned to an MCO by the enrollment broker in accordance with the department's algorithm/formula and the provisions of §3105.E:

a. mandatory MCO participants, with the exceptions noted in §3105.G.2.a.i.;

b. pregnant women with Medicaid eligibility limited to prenatal care, delivery and post-partum services; and

c. other recipients as determined by the department.

2. MCO automatic assignments shall take into consideration factors including, but not limited to:

a. assigning members of family units to the same MCO;

b. existing provider-enrollee relationships;

c. previous MCO-enrollee relationship;

d. MCO capacity; and

e. MCO performance outcome indicators.

3. MCO assignment methodology shall be available to recipients upon request to the enrollment broker.

I. Selection or Automatic Assignment of a Primary Care Provider for Mandatory Populations for All Covered Services

1. The MCO is responsible to develop a PCP automatic assignment methodology in accordance with the department’s requirements for the assignment of a PCP to an enrollee who:

a. does not make a PCP selection after being offered a reasonable opportunity by the MCO to select a PCP;

b. selects a PCP within the MCO that has reached their maximum physician/patient ratio; or

c. selects a PCP within the MCO that has restrictions/limitations (e.g. pediatric only practice).

2. The PCP automatically assigned to the member shall be located within geographic access standards, as specified in the contract, of the member's home and/or who best meets the needs of

the member. Members for whom an MCO is the secondary payor will not be assigned to a PCP by the MCO, unless the member requests that the MCO do so.

3. If the enrollee does not select an MCO and is automatically assigned to a PCP by the MCO, the MCO shall allow the enrollee to change PCP, at least once, during the first 90 days from the date of assignment to the PCP. Effective the ninety-first day, a member may be locked into the PCP assignment for a period of up to nine months beginning from the original date that he/she was assigned to the MCO.

4. If a member requests to change his/her PCP for cause at any time during the enrollment period, the MCO must agree to grant the request.

J. Lock-In Period

1. Members have 90 days from the initial date of enrollment into an MCO in which they may change the MCO for any reason. Medicaid enrollees may only change MCOs without cause within the initial 90 days of enrollment in an MCO. After the initial 90-day period, Medicaid enrollees/members shall be locked into an MCO until the annual open enrollment period, unless disenrolled under one of the conditions described in this Section, with the exception of the mandatory, opt-in populations, who may disenroll from Bayou Health for physical health and return to legacy Medicaid at any time.

K. Annual Open Enrollment

1. The department will provide an opportunity for all MCO members to retain or select a new MCO during an annual open enrollment period. Notification will be sent to each MCO member and voluntary members who have opted out of participation in Bayou Health at least 60 days prior to the effective date of the annual open enrollment. Each MCO member shall receive information and the offer of assistance with making informed choices about MCOs in their area and the availability of choice counseling.

2. Members shall have the opportunity to talk with an enrollment broker representative who shall provide additional information to assist in choosing the appropriate MCO. The enrollment broker shall provide the individual with information on each MCO from which they may select.

3. During the open enrollment period, each Medicaid enrollee shall be given the option to either remain in their existing MCO or select a new MCO.

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 37:1574 (June 2011), amended LR 40:310 (February 2014), LR 40:1097 (June 2014), LR 41:929 (May 2015), LR 41:

§3107. Disenrollment and Change of Managed Care Organization

A. – D.1.e.ii. ...

iii. the member’s active specialized behavioral health provider ceases to contract with the MCO; or

iv. documented lack of access to providers experienced in dealing with the enrollee’s health care needs.

E. Involuntary Disenrollment

1. The MCO may submit an involuntary disenrollment request to the enrollment broker, with proper documentation for fraudulent use of the MCO identification card. In such cases, the MCO shall report the incident to the Bureau of Health Services Financing.

a. – b. Repealed.

2. – 4.f. ...

g. uncooperative or disruptive behavior resulting from his or her special needs;

h – i. ...

F. Department Initiated Disenrollment

1. The department will notify the MCO of the member's disenrollment or change in eligibility status due to the following reasons:

F.1.a. – G.2. ...

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 37:1575 (June 2011), amended LR 40:311 (February 2014), LR 41:931 (Mary 2015), LR 41:

§3109. Member Rights and Responsibilities

A. – A.10. ...

11. be furnished health care services in accordance with all other applicable federal regulations.

B. – C.8. ...

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 37:1576 (June 2011), amended LR 40:311 (February 2014), LR 41:930 (May 2015), LR 41:

Chapter 35. Managed Care Organization Participation Criteria

§3501. Participation Requirements

A. – B.5. ...

6. have a network capacity to enroll a minimum of 250,000 Medicaid and LaCHIP eligibles; and

7. – 9. ...

C. An MCO shall ensure the provision of core benefits and services to Medicaid enrollees as specified in the terms of the contract.

D. – I.4. ...

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 37:1583 (June 2011), amended LR 41:933 (May 2015), LR 41:

§3503. Managed Care Organization Responsibilities

A. – P.1. ...

a. The MCO must submit all proposed changes to the member handbooks and/or provider handbooks to the department for review and approval in accordance with the terms of the contract and the department issued guides.

b. ...

Q. The member handbook shall include, but not be limited to:

1. – 3. ...

a. a member's right to disenroll from the MCO, including disenrollment for cause;

3.b. – 4.c. ...

5. the amount, duration, and scope of benefits available under the MCO's contract with the department in sufficient detail to ensure that members have information needed to aid in understanding the benefits to which they are entitled including, but not limited to:

a. specialized behavioral health;

b. information about health education and promotion programs, including chronic care management;

c. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

d. how members may obtain benefits, including family planning services, from out-of-network providers;

e. how and where to access any benefits that are available under the Louisiana Medicaid State Plan, but are not covered under the MCO's contract with the department;

f. information about early and periodic screening, diagnosis and treatment (EPSDT) services;

g. how transportation is provided, including how to obtain emergency and non-emergency medical transportation;

h. the post-stabilization care services rules set forth in 42 CFR 422.113(c);

i. the policy on referrals for specialty care, including specialized behavioral health services and other benefits not furnished by the member's primary care provider;

j. for counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO is required to furnish information on how or where to obtain the service;

k. how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";

l. the extent to which and how after-hour crisis and emergency services are provided; and

m. information about the MCO's formulary and/or preferred drug list (PDL), including where the member can access the most current information regarding pharmacy benefits;

6. – 7. ...

8. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English and Spanish;

9. grievance, appeal, and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and the MCO's contract with the department; and

10. information regarding specialized behavioral health services, including but not limited to:

a. a description of covered behavioral health services;

b. where and how to access behavioral health services and behavioral health providers, including emergency or crisis services;

c. general information on the treatment of behavioral health conditions and the principles of:

i. adult, family, child, youth and young adult engagement;

ii. resilience;

iii. strength-based and evidence-based practices; and

iv. best/proven practices;

d. description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and

e. any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment, as per 42 CFR Part 2.

R. The provider handbook shall include, but not be limited to:

1. – 4. ...

5. grievance and appeals procedures and process;

6. other policies, procedures, guidelines, or manuals containing pertinent information related to operations and pre-processing claims;

7. description of the MCO;

8. core benefits and services the MCO must provide, including a description of all behavioral health services;

9. information on how to report fraud, waste and abuse; and

10. information on obtaining transportation for members.

S. The provider directory for members shall be developed in four formats:

1. ...

2. an accurate electronic file refreshed weekly of the directory in a format to be specified by the department and used to populate a web-based online directory for members and the public;

3. an accurate electronic file refreshed weekly of the directory for use by the enrollment broker; and

4. a hard copy abbreviated version, upon request by the enrollment broker.

T. – T.1. ...

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 37:1583 (June 2011), amended LR 39:92 (January 2013), LR 40:66 (January 2014), LR 41:933 (May 2015), LR 41:

§3507. Benefits and Services

A. – C.4. ...

D. The following is a summary listing of the core benefits and services that an MCO is required to provide:

1. – 5. ...

6. EPSDT/well child visits, excluding applied behavior analysis (ABA) therapy services and dental services;

7. – 12. ...

13. basic and specialized behavioral health services, excluding Coordinated System of Care services;

14. – 18. ...

19. pharmacy services (outpatient prescription medicines dispensed, with the exception of those who are enrolled in Bayou Health for behavioral health services only, or the contractual responsibility of another Medicaid managed care entity):

a. specialized behavioral health only members will receive pharmacy services through legacy Medicaid;

20. ...

21. personal care services (age 0-20);

22. pediatric day healthcare services;

23. audiology services;

24. ambulatory surgical services;

25. laboratory and radiology services;

26. emergency and surgical dental services;

27. clinic services;

28. pregnancy-related services;

29. pediatric and family nurse practitioner services;

30. licensed mental health professional services, including advanced practice registered nurse (APRN) services;

31. federally qualified health center (FQHC)/rural health clinic (RHC) services;

32. early stage renal disease (ESRD) services;

33. optometry services;

34. podiatry services;

35. rehabilitative services, including crisis stabilization;

36. respiratory services; and

37. section 1915(i) services.

NOTE: ...

E. Transition Provisions

1. In the event a member transitions from an MCO included status to an MCO excluded status or MCO specialized behavioral health only status before being discharged from a hospital and/or rehabilitation facility, the cost of the entire admission will be the responsibility of the MCO. This is only one example and does not represent all situations in which the MCO is responsible for cost of services during a transition.

E.2. – F.1. ...

G. Excluded Services

1. The following services will continue to be reimbursed by the Medicaid Program on a fee-for-service basis, with the exception of dental services which will be reimbursed through a dental benefits prepaid ambulatory health plan under the authority of a 1915(b) waiver. The MCO shall provide any appropriate referral that is medically necessary. The department shall have the right to incorporate these services at a later date if the member capitation rates have been adjusted to incorporate the cost of such service. Excluded services include:

a. ...

b. intermediate care facility services for persons with intellectual disabilities;

c. personal care services (age 21 and over);

d. nursing facility services;

e. individualized education plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures;

f. ABA therapy services;

g. targeted case management services; and

h. all OAAS/OCDD home and community-based §1915(c) waiver services.

i. Repealed.

H. Utilization Management

1. ...

a. The MCO shall submit UM policies and procedures to the department for written approval annually and subsequent to any revisions.

2. – 5. ...

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 37:185 (June 2011), amended LR 39:92 (January 2013), repromulgated LR 39:318 (February 2013), LR 41:936 (May 2015), LR 41:

§3509. Reimbursement Methodology

A. ...

1. The department will establish monthly capitation rates within an actuarially sound rate range certified by its actuaries. Consistent with all applicable federal rules and regulations, the rate range will initially be developed using fee-for-service claims data, Bayou Health shared savings claims data, Bayou Health managed care organization encounter data, Louisiana Behavioral Health Partnership (LBHP) encounter data, financial data reported by Bayou Health plans and the LBHP statewide

management organization, supplemental ad hoc data, and actuarial analyses with appropriate adjustments.

2. ...

3. Capitation rates will be set for all MCOs at the beginning of each contract period and will be periodically reviewed and adjusted as deemed necessary by the department.

a. – d. Repealed.

4. Capitation rates for physical and basic behavioral health will be risk-adjusted for the health of Medicaid enrollees enrolled in the MCO. Capitation rates for specialized behavioral health will not be risk-adjusted.

a. The health risk of the Medicaid enrollees enrolled in the MCO will be measured using a national-recognized risk-assessment model.

b. Utilizing this information, the capitation rates will be adjusted to account for the health risk of the enrollees in each MCO relative to the overall population being measured.

c. The health risk of the members and associated MCO risk scores will be updated periodically to reflect changes in risk over time.

d. The department will provide the MCO with advance notice of any major revision to the risk-adjustment methodology.

5. An MCO shall be reimbursed a one-time supplemental lump sum payment, hereafter referred to as a "maternity kick payment", for each obstetrical delivery in the amount determined by the department's actuary.

a. The maternity kick payment is intended to cover the cost of prenatal care, the delivery event, and postpartum care. Payment will be paid to the MCO upon submission of satisfactory evidence of the occurrence of a delivery.

b. Only one maternity kick payment will be made per delivery event. Therefore, multiple births during the same delivery will still result in one maternity kick payment being made.

c. The maternity kick payment will be paid for both live and still births. A maternity kick payment will not be reimbursed for spontaneous or induced abortions.

6. Capitation rates related to pharmacy services will be adjusted to account for pharmacy rebates.

B. – E. ...

F. An MCO shall have a medical loss ratio (MLR) for each MLR reporting year, which shall be a calendar year.

1. Following the end of the MLR reporting year, an MCO shall provide an annual MLR report, in accordance with the financial reporting guide issued by the department.

2. The annual MLR report shall be limited to the MCO's medical loss ratio for services provided to Medicaid enrollees and payment received under the contract with the department, separate from any other products the MCO may offer in the state of Louisiana.

3. An MLR shall be reported in the aggregate, including all services provided under the contract.

a. The aggregate MLR shall not be less than 85 percent using definitions for health care services, quality initiatives and administrative cost as specified in 45 CFR Part 158. If the aggregate MLR is less than 85 percent, the MCO will be subject to refund the difference, within the timeframe specified, to the department. The portion of any refund due the department that has not been paid, within the timeframe specified, will be subject to interest at the current Federal Reserve Board lending rate or in the amount of 10 percent per annum, whichever is higher.

b. The department may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health. Neither the 85 percent minimum nor the refund applicable to the aggregate shall apply to distinct MLRs reported.

4. The department shall provide for an audit of the MCO's annual MLR report and make public the results within 60 calendar days of finalization of the audit.

G. – N.2.a. ...

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 37:1587 (June 2011), amended LR 39:92 (January 2013), repromulgated LR 39:318 (February 2013), LR 41:937 (May 2015), LR 41:

Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3705. General Provisions

A. ...

B. Filing Requirements

1. Authority to file. A member, or a representative of his/her choice, including a network provider acting on behalf of the member and with the member's consent, may file a grievance and an MCO level appeal. Once the MCO's appeals process has been exhausted, a member or his/her representative, with the member's written consent, may request a state fair hearing.

B.1.a. – J. ...

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 37:1590 (June 2011), amended LR 41:939 (May 2015), LR 41:

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Medicaid Eligibility
Louisiana Health Insurance Premium Payment Program Termination
(LAC 50:III.2311)

The Department of Health and Hospitals, Bureau of Health Services Financing has repealed LAC 50:III.2311 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 III. Eligibility
Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2311. Louisiana Health Insurance Premium Payment Program

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 35:1111 (June 2009), repealed LR 41:

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
and
Office of Behavioral Health

Psychiatric Residential Treatment Facilities
(LAC 50:XXXIII Chapters 101-107)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 101-107 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 11. Psychiatric Residential Treatment Facility Services

Chapter 101. General Provisions

§10101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for behavioral health services rendered to children and youth in an inpatient psychiatric residential treatment facility (PRTF). These services shall be administered under the authority of the Department of Health and Hospitals, in collaboration with managed care organizations and the coordinated system of care

(CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. …

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 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§10103. Recipient Qualifications

A. Individuals under the age of 21 with an identified mental health or substance use diagnosis, who meet Medicaid eligibility and clinical criteria, shall qualify to receive inpatient psychiatric residential treatment facility 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 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 103. Services

§10301. General Provisions

A. – C.1. …

D. Children who are in need of behavioral health services shall be served within the context of the family and not as an isolated unit.

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 children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

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 38:369 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§10303. Covered Services

A. - B.1. ...

2. group education, including elementary and secondary education; and

3. activities not on the inpatient psychiatric active treatment plan.

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 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 105. Provider Participation

§10501. Provider Responsibilities

A. Each provider of PRTF services shall enter into a contract with one or more of the MCOs and the CSoC contractor in order to receive reimbursement for Medicaid covered services.

B. – C. …

D. Anyone providing PRTF 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. PRTF facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to its contracted MCOs and the CSoC contractor in writing within the time limit established 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 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 107. Reimbursement

§10701. General Provisions

A. For recipients enrolled with the CSoC contractor, reimbursement for services shall be based upon the established Medicaid fee schedule for behavioral health services. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to

the MCOs. 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. Covered inpatient, physician-directed PRTF services rendered to children and youth shall be reimbursed according to the following criteria:

1. Free-Standing PRTF Facilities. The per diem rate shall include reimbursement for the following services when included on the active treatment plan:

a. – e. …

2. A free-standing PRTF shall arrange through contract(s) with outside providers to furnish dental, vision, and diagnostic/radiology treatment activities as listed on the treatment plan. The treating provider will be directly reimbursed by the MCO or the CSoC contractor.

3. Hospital-Based PRTF Facilities. A hospital-based PRTF facility shall be reimbursed a per diem rate for covered services. The per diem rate shall also include reimbursement for the following services when included on the active treatment plan:

a. – d. …

4. Pharmacy and physician services shall be reimbursed when included on the recipient’s active plan of care and are components of the Medicaid covered PRTF services. The

MCO or the CSoC contractor shall make payments directly to the treating physician. The MCO shall also make payments directly to the pharmacy. These payments shall be excluded from the PRTF's contracted per diem rate for the facility.

B. All in-state Medicaid participating PRTF providers are required to file an annual Medicaid cost report in accordance with Medicare/Medicaid allowable and non-allowable costs.

C. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end. Separate cost reports must be filed for the facility's central/home office when costs of that entity are reported on the facility's cost report. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date.

1. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

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 38:370 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§10703. In-State Publicly Owned and Operated Psychiatric Residential Treatment Facilities

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 38:370 (February 2012), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§10703. Reimbursement Methodology (Reserved)

§10705. In-State Psychiatric Residential Treatment Facilities

A. In-State publicly and privately owned and operated PRTFs shall be reimbursed for covered PRTF services according to the following provisions. The rate paid by the MCO or the CSoC contractor shall take into consideration the following ownership and service criteria:

1. free-standing PRTFs specializing in sexually-based treatment programs;

2. free-standing PRTFs specializing in substance use treatment programs;

3. free-standing PRTFs specializing in behavioral health treatment programs;

4. hospital-based PRTFs specializing in sexually-based treatment programs;

5. hospital-based PRTFs specializing in substance use treatment programs; and

6. hospital-based PRTFs specializing in behavioral health treatment programs.

B. – 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, Bureau of Health Services Financing, LR 38:370 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§10707. Out-of-State Psychiatric Residential Treatment Facilities

A. Out-of-state PRTFs shall be reimbursed in accordance with the MCO or CSoC contractor’s established 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 38:370

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

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
and
Office of Behavioral Health

Therapeutic Group Homes
Behavioral Health Integration
(LAC 50:XXXIII.Chapters 121-127)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 121-127 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 13. Therapeutic Group Homes

Chapter 121. General Provisions

§12101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for behavioral health services rendered to children and youth in a therapeutic group home (TGH). These services shall be administered under the authority of the Department of Health and Hospitals, in collaboration with managed care organizations (MCOs) and the

coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery. The CSoC contractor shall only manage specialized behavioral health services for children/youth enrolled in the CSoC program.

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

C. A therapeutic group home provides a community-based residential service in a home-like setting of no greater than 10 beds under the supervision and program oversight of a psychiatrist or psychologist.

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§12103. Recipient Qualifications

A. …

B. Qualifying children and adolescents with an identified mental health or substance use diagnosis shall be eligible to receive behavioral health services rendered by a TGH.

C. – C.3. …

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 123. Services

§12301. General Provisions

A. – C.1. …

D. Children who are in need of behavioral health services shall be served within the context of the family and not as an isolated unit.

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 children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§12303. Covered Services

A. – B.2. …

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;

4. – 6. …

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 125. Provider Participation

§12501. Provider Responsibilities

A. Each provider of TGH services shall enter into a contract with one or more of the MCOs and the CSoC contractor for youth enrolled in the CSoC program in order to receive reimbursement for Medicaid covered services. Providers shall meet the provisions of this Rule, the provider manual, and the appropriate statutes.

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. Any services that exceed established limitations beyond the initial authorization must be approved for re-authorization prior to service delivery.

D. Anyone providing TGH services must be certified by the department, or its designee, in addition to operating within their scope of practice license.

E. TGH facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to their contracted MCOs and the CSoC contractor for youth enrolled in the CSoC program in writing within the time limit established by the department.

F. Providers of TGH services shall be required to perform screening and assessment services upon admission and within the timeframe established by the department 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.

G. A TGH must ensure that youth are receiving appropriate therapeutic care to address assessed needs on the child's treatment plan.

1. Therapeutic care may include treatment by TGH staff, as well as community providers.

2. Treatment provided in the TGH or in the community should incorporate research-based approaches appropriate to the child's needs, whenever possible.

H. For TGH facilities that provide care for sexually deviant behaviors, substance abuse, or dually diagnosed individuals, the facility shall submit documentation to their contracted MCOs and the CSoC contractor for youth enrolled in the CSoC program regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with ASAM level of care being provided.

I. A TGH must incorporate at least one research-based approach pertinent to the sub-populations of TGH clients to be served by the specific program. The specific research-based model to be used should be incorporated into the program description. The research-based models must be approved by OBH.

J. A TGH must provide the minimum amount of active treatment hours established by the department, and performed by qualified staff per week for each child, consistent with each child's plan of care and meeting assessed needs.

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 127. Reimbursement

§12701. General Provisions

A. For recipients enrolled with the CSoC contractor, reimbursement for services shall be based upon the established Medicaid fee schedule for specialized behavioral health services. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs. 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.

1. Reimbursement for covered TGH services shall be inclusive of, but not limited to:

a. – d. …

2. Allowable and non-allowable costs components, as defined by the department.

B. All in-state Medicaid participating TGH providers are required to file an annual Medicaid cost report according to the department's specifications and departmental guides and manuals.

C. Costs reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end. Separate cost reports must be filed for the facilities central/home office when costs of

that entity are reported on the facilities cost report. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date.

1. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

D. Services provided by psychologists and licensed mental health practitioners shall be billed to the MCO or CSoC contractor separately.

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 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§12703. In-State Privately Owned and Operated Therapeutic Group Homes

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 38:429 (February 2012), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR:41

§12703. Reimbursement Methodology (Reserved)

§12705. In-State Therapeutic Group Homes

A. In-state publicly and privately owned and operated therapeutic group homes shall be reimbursed according to the MCO or CSoC contractor established rate within their contract.

B. 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 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR:41

§12707. Out-of-State Therapeutic Group Homes

A. Out-of-state therapeutic group homes shall be reimbursed for their services according to the rate established by the MCO or CSoC contractor.

B. Payments to out-of-state TGH facilities that provide covered services shall not be subject to TGH cost reporting requirements.

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 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

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