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, Office of Behavioral Health in collaboration with a statewide management organization (SMO) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The 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 eight 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).

§12103. Recipient Qualifications

A. Individuals under the age of 21, who meet Medicaid eligibility and clinical criteria, shall qualify to receive therapeutic group home services.

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

C. In order for a child to receive TGH services:

1. the department, or its designee, must have determined that less intensive levels of treatment are unsafe, unsuccessful, or unavailable;

2. the child must require active treatment that would not be able to be provided at a less restrictive level of care on a 24-hour basis with direct supervision/oversight by professional behavioral health staff; and

3. the child must attend a school 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 38:427 (February 2012).

Chapter 123. Services

§12301. General Provisions

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

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

C. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision making authority for a child or adolescent in state custody must request and 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. Services shall be appropriate for:

1. age;

2. development;

3. education; and

4. culture.

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).

§12303. Covered Services

A. The Medicaid Program may reimburse a therapeutic group home for the following services:

1. screening and assessment services;

2. therapy services (individual, group, and family whenever possible);

3. on-going psychiatric assessment and intervention as needed; and

4. skill-building services.

B. Service Exclusions. The following services/components 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 substance abuse services;

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

5. room and board; and

6. supervision associated with the child's stay in the TGH.

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).

Chapter 125. Provider Participation

§12501. Provider Responsibilities

A. Each provider of TGH services shall enter into a contract with the Statewide Management Organization in order to receive reimbursement for Medicaid covered services.

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

C. Providers of TGH 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 TGH services must be certified by the department 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 the SMO 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 abuse issues.

G. Annually, TGH facilities shall submit documentation demonstrating compliance with fidelity monitoring for at least two evidence-based practices (EBP) and/or one level of American Society of Addiction Medicine (ASAM) criteria. The Office of Behavioral Health (OBH) shall approve the auditing body providing the EBP/ASAM fidelity monitoring.

H. For TGH facilities that provide care for sexually deviant behaviors, substance abuse, or dually diagnosed individuals, the facility shall submit documentation 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 two research-based approaches pertinent to the sub-populations of TGH clients to be served by the specific program. The specific research-based models to be used should be incorporated into the program description. 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 treatment plan 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).

Chapter 127. Reimbursement

§12701. Reimbursement Methodology

A. Reimbursement for covered TGH services shall be based upon an interim Medicaid per diem payment.

1. The interim Medicaid per diem payment shall be inclusive of, but not limited to:

a. allowable cost of clinical and related services;

b. psychiatric support services;

c. allowable cost of integration with community resources; and

d. skill-building services provided by unlicensed practitioners.

2. Allowable and non-allowable costs components, as defined by the department, shall be outlined in the TGH provider manual and other departmental guides.

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. The cost report period shall correspond to a calendar year basis of January 1 through December 31.

C. Services provided by psychologists and licensed mental health practitioners shall be billed separately and reimbursed according to the established Medicaid fee schedule for the services rendered.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:429 (February 2012).

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

A. In-state privately owned and operated therapeutic group homes shall be reimbursed for covered TGH services through a modeled interim Medicaid per diem reimbursement rate using estimated allowable cost for the TGH covered services and staffing requirements.

B. Retroactive Adjustments to the Interim Rates. Interim payments to in-state privately owned and operated TGH facilities shall be subject to retroactive rate adjustments according to the following criteria.

1. The facility's allowable per diem cost will be determined from the Medicaid cost report submitted. The provider will receive a retroactive rate adjustment equal to 50 percent of the difference between the actual Medicaid allowable per diem cost and the interim Medicaid per diem reimbursement rate for each covered TGH patient day.

2. The payment adjustment will not recognize provider allowable cost beyond the threshold of 125 percent of the initial Medicaid per diem reimbursement rate paid during each fiscal year.

3. Providers who have disclaimed cost reports or are non-filers will be subject to the modification of the payment adjustment as deemed appropriate 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 38:429 (February 2012).

§12705. In-State Publicly Owned and Operated Therapeutic Group Homes

A. In-state publicly owned and operated therapeutic group homes shall be reimbursed for all reasonable and necessary cost of operation. These facilities shall receive the interim Medicaid per diem payment established for the in-state privately owned and operated TGH facilities according to the provisions of §12703.A.

B. The interim payment to in-state publicly owned and operated TGH facilities will be subject to retroactive cost settlement in accordance with Medicare allowable cost principles outlined in the Centers for Medicare and Medicaid Service's Provider Reimbursement Manual Publication 15-1.

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 38:429 (February 2012).

§12707. Out-of-State Therapeutic Group Homes

A. Out-of-state therapeutic group homes shall be reimbursed the lesser of their specific in-state TGH Medicaid per diem reimbursement rate, or 95 percent of the Louisiana interim Medicaid per diem reimbursement rate calculated according to the provisions of §12703.A.

B. Payments to out-of-state TGH facilities that provide covered services shall not be subject to retroactive cost adjustments or 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).

Subpart 15. Substance Abuse Services

Chapter 141. General Provisions

§14101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for substance abuse services rendered to children and adults. These services shall be administered under the authority of the Department of Health and Hospitals, Office of Behavioral Health, in collaboration with a statewide management organization (SMO) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The substance abuse 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).

§14103. Recipient Qualifications

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

B. Qualifying children and adults with an identified substance abuse diagnosis shall be eligible to receive substance abuse 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).

1. age;