

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. increase access to a broad array of evidence-based home and community-based services that promote hope, recovery and resilience;
2. improve quality by establishing and measuring outcomes;
3. manage costs through effective utilization of State, federal, and local resources; and
4. foster reliance on natural supports that sustain individuals and families in homes and communities.

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 41:2353 (November 2015).

§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);
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. recipients enrolled in the Medicare beneficiary programs (QMB, SLMB, QDWI and QI-1);
2. adults who reside in an intermediate care facility for persons with intellectual disabilities (ICF/ID);
3. recipients of refugee cash assistance;
4. recipients of refugee medical assistance;
5. recipients enrolled in the Spend-Down Medically Needy Program;
6. recipients who receive emergency services only coverage;
7. recipients who receive services through the Program of All-Inclusive Care for the Elderly (PACE);
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 41:2354 (November 2015).

§107. Enrollee Rights and Responsibilities

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

1. participate in treatment decisions, including the right to:
 - a. refuse treatment;
 - b. seek second opinions; and
 - d. receive assistance with care coordination from the primary care providers (PCP's) office;
2. express a concern about their provider or the care rendered via a grievance process;
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. receive a copy of his/her medical records;
6. be furnished health care services in accordance with federal regulations, including those governing access standards;
7. choose a participating network health care professional in accordance with federal and state regulations; and
8. be allowed to receive a specialized service outside of the network if a qualified provider is not available through the network.

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. presenting their identification card when accessing behavioral health services;
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. providing participating network providers, or any other authorized provider, with accurate and complete medical information;
6. following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;
7. making every effort to keep any agreed upon appointments and follow-up appointments and contacting the provider in advance if unable to do so; and

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 41:2354 (November 2015).

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;
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.

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 41:2355 (November 2015).

§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. may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;

3. may place appropriate limits on a service:

a. on the basis of medical necessity; and

b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

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. Policy transmittals, State Plan amendments, Rules and regulations, provider bulletins, provider manuals and fee schedules issued by the department are the final authority regarding 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 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2355 (November 2015).

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. An enrollee, or a provider on behalf of an enrollee, must file an appeal within 30 calendar days from the date on the notice of action.

C. An enrollee must file a grievance within 180 calendar days of the occurrence or incident which is the basis for the grievance.

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 41:2356 (November 2015).