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. The behavioral health services provided to children in the HCBS waiver 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.

C. The HCBS waiver is designed as a nursing facility and hospitalization diversion program. The goal of this waiver is to divert nursing facility and psychiatric hospitalization placement through the provision of intensive home and community-based supportive services.

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 41:2361 (November 2015).

§8103. Recipient Qualifications

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

1. are from 0 through the age of 21 years old;

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;

4. require hospital or nursing facility level of care, as determined by the department's designated assessment tools and criteria; and

5. meet financial eligibility criteria.

B. The need for waiver services is re-evaluated at a minimum of every 180 days, and at any time the family feels that it is appropriate, as needs change, and/or as goals are completed. The re-evaluation determines if the recipient continues to be in need of psychiatric hospitalization or nursing facility level 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 38:366 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015).

Chapter 83. Services

§8301. 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 (LMHP) 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 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.

E. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the department.

F. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the plan of care.

G. Services may be provided by a member of the participant's family, provided that the participant does not live in the family member's residence and the family member is not the legally responsible relative.

1. The following family members may provide the services:

a. the parents of an adult recipient;

b. siblings;

c. grandparents;

d. aunts;

e. uncles; and

f. cousins.

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 41:2361 (November 2015).

§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. The POC is reviewed every 90 days with the recipient and parents or caregivers of the recipient. The wraparound facilitator works directly with the recipient, the family (or the recipient's authorized health care decision maker) and others to develop the POC. A crisis plan must be included in each recipient's POC.

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. Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

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 41:2362 (November 2015).

§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.

B. Service Limitations

1. Short term respite care shall be pre-approved for the duration of 72 hours per episode with a maximum of 300 hours allowed per calendar year. Hours in excess of 300 may be authorized when deemed medically necessary.

2. Youth support and training services may not be provided by local education agencies and are limited to 750 hours per calendar year. Hours in excess of 750 may be authorized when deemed medically necessary.

C. 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; and

4. services rendered in an institution for mental disease.

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 41:2362 (November 2015).