

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202



DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

June 7, 2016

Our Reference: SPA LA 15-0029

Ms. Jen Steele, Interim State Medicaid Director
Department of Health and Hospitals
628 North 4th St.
Post Office Box 91030
Baton Rouge, LA 70821-9030

Attention: Darlene Budgewater

Dear Ms. Steele:

We have reviewed the State's proposed amendment to the Louisiana State Plan submitted under Transmittal Number 15-0029 dated November 10, 2015. This state plan amendment amends the provisions governing substance use services to update the terminology and service criteria; revises the provisions governing provider certification; and revises the reimbursement methodology for children's services to reflect the integration of specialized behavioral health services into Bayou Health by establishing a capitated rate for recipients enrolled in one of the managed care organizations (MCOs). The non-risk reimbursement methodology will continue to be utilized for children/youth enrolled in the coordinated system of care (CSoC) through a CSOC contractor.

Based on the information submitted, we have approved the amendment for incorporation into the official Louisiana State Plan with an effective date change of December 1, 2015. A copy of the CMS-179 and approved plan pages are enclosed with this letter.

If you have any questions, please contact Cheryl Rupley at (214) 767-6278 or by email at Cheryl.Rupley@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Bill Brooks". The signature is written in a cursive, slightly slanted style.

Bill Brooks
Associate Regional Administrator

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED BELOW:

CITATION
42 CFR 440.130(d)

Rehabilitation Services

State: Louisiana
Date Received: 11-10-15
Date Approved: 6-7-16
Date Effective: 12-1-15
Transmittal Number: 15-0029

This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It may overlap with Level IV-D services (as a “step-down” service) in a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available.

Limitations:

These SUD services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible individuals with significant functional impairments resulting from an identified addiction diagnosis. Services must be medically necessary and must be recommended by a licensed mental health practitioner or physician, who is acting within the scope of his/her professional license and applicable state law, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan.

The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual’s condition and the standards of practice for the provision of rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing to note concurrence with the treatment plan.

The plan will specify a timeline for re-evaluation of the plan that is at least an annual redetermination. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategies with revised goals and services. Providers must maintain medical records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan.

TN 15-0029
Supersedes
TN New Page

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STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION **Rehabilitation Health Services**
42 CFR 440.130 (d)

Substance Use Disorders Services Reimbursement Methodology

State: Louisiana
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Effective for dates of service on or after March 1, 2012, reimbursements for services are based upon a Medicaid fee schedule established by the State of Louisiana. The reimbursement rates for physician services rendered under the Louisiana Behavioral Health Partnership (LBHP) shall be a flat fee for each covered service as specified on the established Medicaid fee schedule. The reimbursement rates shall be based on a percentage of the Louisiana Medicare Region 99 allowable for a specified year.

- If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay Psychologists and APRNs at 80 percent of the LBHP physician rates. If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay LCSWs, LPCs, LMFTs, and LAC's as well as qualified unlicensed practitioners delivering substance abuse services at 70 percent of the LBHP physician rates.
- Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.
- Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers. The Agency's fee schedule rate was set as of August 1, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com.

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STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION Rehabilitation Health Services
42 CFR 440.130 (d)

- The fee development methodology will primarily be composed of provider cost modeling, though Louisiana provider compensation studies, cost data and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.
 - 1) Staffing Assumptions and Staff Wages
 - 2) Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
 - 3) Program-Related Expenses (e.g., supplies)
 - 4) Provider Overhead Expenses
 - 5) Program Billable Units

- The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

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

Effective for dates of service on or after April 20, 2013, the reimbursement for behavioral health services rendered by a physician under the LBHP shall be 75 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients.

Effective for dates of service on or after September 1, 2013, the reimbursement for procedure codes 90791, 90792, 90832, 90834, and 90837 shall be excluded from the January 2013 Medicare rate changes and shall remain at the Medicaid fee schedule on file as of December 31, 2012.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION Rehabilitation Health Services
42 CFR 440.130 (d)

Effective for dates of service on or after December 1, 2015, substance use disorders services shall be reimbursed as follows:

- Reimbursement for services shall be based upon the established Medicaid fee schedule for SUD services rendered to recipients enrolled with the Coordinated System of Care (CSoC) contractor. The fee schedule is published on the Medicaid provider website at www.lamedicaid.com.
- Monthly capitation payments shall be made by the Department, or its fiscal intermediary, to the managed care organizations (MCOs) for recipients enrolled in 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.

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