John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

May 9, 2016

Bill Brooks
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, TX 75202

Dear Mr. Brooks:

RE: LA SPA TN 15-0029 RAI Response
Substance Use Disorder Services- LBHP Integration

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 15-0029 with a proposed effective date of December 1, 2015. The purpose of this SPA is to amend the provisions governing substance use services to: 1) update the terminology and service criteria; 2) revise the provisions governing provider certification; and 3) revise 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. We are providing the following in response to your request for additional information (RAI) dated February 3, 2016:

CMS -179 Issues

1. This amendment revises the reimbursement methodology for children to reflect the integrations of specialized behavioral health services, yet there is no fiscal impact. Please put a Federal Budget Impact in box 7 of the CMS-179 and provide supporting documentation of the calculation for Federal Fiscal Years 2016 and 2017, or explain why there is no fiscal impact, on the CMS-179.

RESPONSE: All programmatic changes associated with the State Plan amendment will have no fiscal impact on the Medicaid budget. The revisions reflect the integration of existing behavioral health services into the Bayou

Health Managed Care Program and the continuation of a non-risk reimbursement methodology for children/youth.

Coverage Issues

2. The state indicates that Substance Use Disorder services include an array of individual centered outpatient, intensive outpatient, and residential services. On the plan page, please specify the component services available under Substance Use Disorder Service including the practitioner authorized to furnish the component services.

RESPONSE: Please see added language as suggested on Attachment 3.1-A Item 13.d, Pages 6-8. Practitioners authorized to furnish services can be found on Pages 10-11.

Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) of the Social Security Act (the Act) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

RESPONSE: Providers will receive and retain 100 percent of the payments. No portion of the payments is returned to the state.

2. Section 1902(a)(2) of the Act provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide

state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 Code of Federal Regulations (CFR) 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

RESPONSE: The state share is paid from the state general fund which is directly appropriated to the Medicaid agency.

3. Section 1902(a)(30) of the Act requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) of the Act provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

RESPONSE: This SPA does not involve supplemental or enhanced payments.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

RESPONSE: Not applicable to this State Plan amendment.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

RESPONSE: We do not have any public/governmental providers receiving payments that exceed their reasonable costs of services provided.

Please consider this a formal request to begin the 90-day clock. We trust that this additional information will be sufficient to result in the approval of the pending plan amendment. We look forward to negotiating with CMS to ensure approval. As always, we appreciate the assistance of CMS in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone at (225) 342-3881.

Sincerely,

Jen Steele
Interim Medicaid Director

JS:DAB:JH

Attachments (2)

c: Darlene Budgewater
Cheryl Rupley

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0029**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **December 1, 2015**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subparts B & F

7. FEDERAL BUDGET IMPACT:
a. FFY **2016** **$0**
b. FFY **2017** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Item 13.d, Pages 5 and 6
Attachment 3.1-A, Item 13.d, Pages 7 ~~and~~ 8 , 9, 10 and 11
Attachment 4.19-B, Item 13.d, Page 4
Attachment 4.19-B, Item 13.d, Page 4a
Attachment 4.19-B, Item 13.d, Page 4b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

SAME (TN 11-10)
NONE – New Pages
SAME (TN 13-38)
SAME (TN 13-19)
NONE – New Page

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing substance abuse services to: 1) update the terminology and service criteria; 2) revise the provisions governing provider certification; and 3) revise 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.**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
November 10, 2015

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

The State requests page substitutions (from original submission) for Attachment 3.1-A, Item 13d, Pages 5-8 and to add new Pages 9-11 (see revised box 8 above).

FORM HCFA-179 (07-92)

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

Substance Use Disorder Services

The Medicaid program provides coverage under the Medicaid State Plan for substance use disorders (SUD) services rendered to children and adults. 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. Children and adults who meet Medicaid eligibility and clinical criteria shall qualify to receive medically necessary SUD services. Qualifying children and adults with an identified SUD diagnosis shall be eligible to receive SUD services.

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

The American Society of Addiction Medicine (ASAM) levels of care require previews on an ongoing basis as determined necessary by Department of Health and Hospitals (DHH) to document compliance with the national standards.

These services include a continuum of individually centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs. The rehabilitation and recovery focus is designed to promote skills for coping with and managing substance use symptoms and behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to undermine the goals of treatment.

CITATION
42 CFR 440.130(d)

Rehabilitation Services

The following ASAM levels are covered for outpatient treatment:

Level I: Outpatient
Outpatient level 1 services are professionally directed assessment, diagnosis, treatment and recovery services provided in a non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure.

Level II.1 Intensive Outpatient Treatment
Intensive outpatient treatment is professionally directed assessment, diagnosis, treatment and recovery services provided in non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure.

These services include, but are not limited to, individual, group, family counseling and psycho-education on recovery, as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis intervention coverage and orientation to community-based support groups. Intensive outpatient program services should include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and multidimensional family therapy.

Level II-D Ambulatory Detoxification with Extended On-site Monitoring
This level of care is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, detoxification and referral services. These services are designed to achieve safe withdrawal from mood-altering chemicals and to effectively facilitate the individual's entry into ongoing treatment and recovery. Counseling services may be available through the detoxification program or may be accessed through affiliation with entities providing outpatient services. Ambulatory detoxification is provided in conjunction with intensive outpatient treatment services (Level II.1).

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

The following ASAM levels are covered for residential treatment:

Level III.1 Clinically Managed Low Intensity Residential Treatment – Adolescent and Adult

Residential programs offer at least five hours per week of a combination of low-intensity clinical and recovery-focused services. All facilities are licensed by DHH. Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on site. Does not include sober houses, boarding houses or group homes where treatment services are not provided (ex: halfway house).

Level III.2D Clinically Managed Residential Social Detoxification – Adolescent and Adult

Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring, observation and support in a supervised environment for a person served, to achieve initial recovery from the effects of alcohol and/or other drugs. All facilities are licensed by DHH.

Social detoxification is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less restrictive, non-medical alternative to inpatient detoxification.

Level III.3 Clinically Managed Medium Intensity Residential Treatment - Adult
Residential programs offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services. All facilities are licensed by DHH. Frequently referred to as extended or long-term care, Level III.3 programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery from substance-related disorders.

CITATION
42 CFR 440.130(d)

Rehabilitation Services

Level III.5 Clinically Managed High Intensity Residential Treatment – Adolescent and Adult
Designed to treat persons who have significant social and psychological problems. All facilities are licensed by DHH. Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. (Example: therapeutic community or residential treatment center.) The program must include an in-house education/vocational component if serving adolescents.

Level III.7 Medically Monitored Intensive Residential Treatment – Adult
The Co-occurring Disorder (COD) residential treatment facility provides 24 hours of structured treatment activities per week including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, habilitative and rehabilitation services to individuals with co-occurring psychiatric and substance disorders (ICOPSD), whose disorders are of sufficient severity to require a residential level of care. All facilities are licensed by DHH.

It also provides a planned regiment of 24-hour professionally directed evaluation, observation and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. Appropriate for patients whose subacute biomedical and emotional, behavior or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health.

Level III.7D Medically Monitored Residential Detoxification – Adult
Medically monitored residential detoxification is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. All facilities are licensed by DHH.

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

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.

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

Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

Services provided at a work site must not be job tasks oriented and must be directly related to treatment of an individual's needs. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institute for mental disease (IMD). Room and board is excluded from any rates provided in a residential setting.

Unless otherwise specified, a unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set.

Provider qualifications:

All services shall be delivered in accordance with federal and state laws and regulations, the provider manual, and other notices or directives issued by the Department. Anyone providing SUD services must operate within their scope of practice license. Providers shall meet the provisions of the provider manual and the appropriate statutes.

Services are provided by licensed and unlicensed professional staff, who are at least 18 years of age with a high school or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by state law and regulations and departmentally approved guidelines. Anyone who is unlicensed providing addiction services must be registered with the Addictive Disorders Regulatory Authority and demonstrate competency as defined by DHH, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. State regulations require supervision of unlicensed professionals by a qualified professional supervisor (QPS).

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

A QPS includes the following professionals who are currently registered with their respective Louisiana board:

a. licensed psychologists;
b. licensed clinical social workers;
c. licensed professional counselors;
d. licensed addiction counselors;
e. licensed physicians; and
f. advanced practice registered nurses.

The following professionals may obtain QPS credentials:

a. a masters-prepared individual who is registered with the appropriate state board and under the supervision of a licensed psychologist;
b. licensed professional counselor (LPC); or
c. licensed clinical social worker (LCSW).

The QPS can provide clinical/administrative oversight and supervision of staff.

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.